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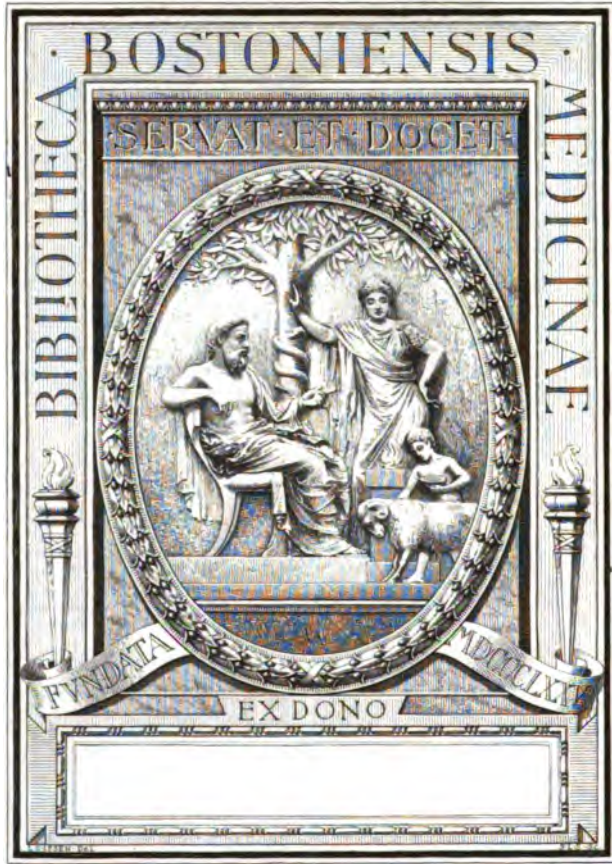
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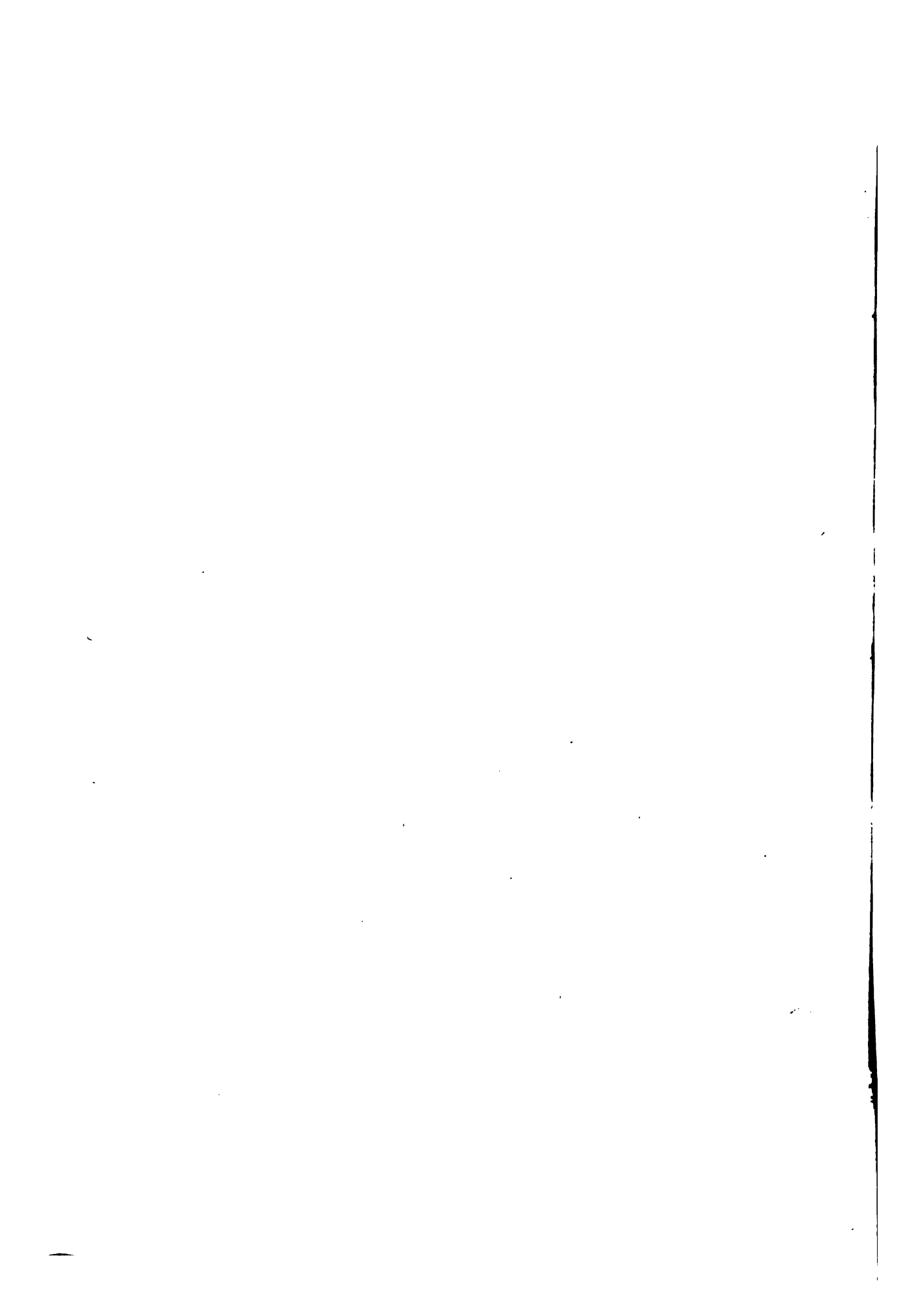












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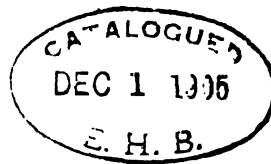
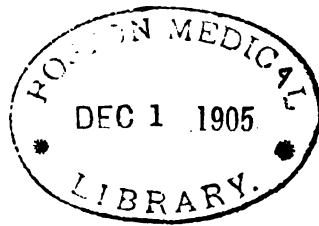
MEDICINE AND MEDICAL AFFAIRS.

FROM JULY TO DECEMBER,

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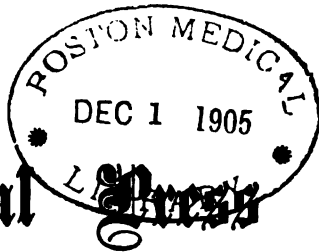
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## Original Communications.

### PESSARIES :

#### THEIR USES AND LIMITATIONS. (a)

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IN considering the question of pessaries, it is well that we should firmly grasp the principles underlying their use in the treatment of displacements of the female pelvic organs. Briefly, their uses are :—

1. To effect a cure, as in some cases of backward displacement, where the uterus may be expected to retain its proper position unaided, after it has been maintained in that position for some time by means of a pessary.
2. As a temporary expedient, whilst waiting for operation, and in cases of retroversion of the gravid uterus, where the normal position will be maintained when the uterus has attained a certain size.
3. As a palliative measure, when radical, that is, operative, treatment is impracticable, undesirable, or declined by the patient.

These are the broad principles ; and the precise indications will be presently set forth in detail.

Before proceeding further, we must disabuse ourselves of certain fallacies, which appear to be widely spread and deeply rooted in the minds either of the public or of members of our profession. Among these fallacies we may signalise the following :—

That the vagina is a natural predestined receptacle for a pessary of some kind.

That the vagina is a grave in which a pessary may be interred, undisturbed, and without hope of resurrection.

That a pessary is a good and proper placebo in all obscure and intractable disorders of the pelvic organs, and in nervous disturbances generally.

That anteversion of the uterus is a displacement.

That a rubber ring pessary is generally serviceable in backward displacements.

That a displacement necessarily requires local treatment.

Another fallacy formerly in vogue, if we may judge by what we may see in instrument-makers' catalogues, but now, I think, relegated to the limbo of discredited traditions, is the supposition that the first stage in the career of a would-be women's specialist is the invention of a new pessary or the modification of an old one.

Pessaries are not an unmixed blessing to woman-

kind ; they have drawbacks and potential risks ; but as they are necessary in certain cases, we may qualify our disapproval of them by describing them as a necessary evil. In some cases where their use might be otherwise called for, there are definite contra-indications. Among these we may enumerate the following :—All inflammatory conditions of the pelvic organs, including vaginitis, endometritis, pelvic peritonitis and cellulitis ; and inflammatory disease of the appendages, ulceration of the vagina, erosion of the cervix, pregnancy in the later months, displacements due to tumours, and incorrigible displacements, namely, such as are associated with fixation due to adhesions. I have several times had occasion to remove a pessary from a case in which the fundus of the uterus was firmly held by adhesions in the pouch of Douglas. I have removed pessaries from cases where the instrument was lying in a pool of muco-pus derived from a raw, red erosion of the cervix, and I have found them adding to the discomfort of a patient with a uterine fibroid, when there was barely room for the uterus and tumour. It may appear superfluous to suggest that a normal condition of the pelvic organs is a contra-indication to the use of a pessary ; yet I have not infrequently removed supports, generally rubber rings, from cases where every organ was normal and in good position. These have generally been neurotic cases, where no doubt the medical attendant has despaired of relieving the multifarious aches and pains complained of, and has introduced a pessary as a sort of placebo, a material sign on which the patient may rest her faith that she is getting better. In my experience, the more normal organs are interfered with in the hope of relieving obscure symptoms, the worse do those symptoms become. All these are instances of the abuse of pessaries. Properly-fitting pessaries, rightly applied, in suitable cases, have enough to answer for in the way of drawbacks and complications, without the reputation of this therapeutic measure being further damaged and prejudiced by their use in unsuitable and normal cases.

*Indications for the Use of Pessaries.*—I now pass on to consider the conditions where pessaries are of service, and the particular kind to be used in each case. These conditions fall into three classes, which may, however, be more or less combined :—

1. Hernia of the vaginal walls, that is, cystocele and rectocele.
2. Prolapse and procidentia of the uterus.
3. Backward displacements of the uterus.

1. *Hernia of the Vaginal Walls.*—In uncom-

a) A Paper read before the North-East London Clinical Society.

plicated cases of cystocele and rectocele, a rubbering pessary usually answers best, whether there be a cystocele alone, a rectocele alone, or a combination of the two. But in some cases of cystocele a ring does not answer, owing to the tendency of the anterior vaginal wall to slip down in front of the pessary; and I have then sometimes found an inverted Hodge, with a single curve, meet the case. When a rubber ring is used, it should be thick in section, as in the Meyer pattern; if a large, thin ring be introduced, the vaginal wall will come down through it. Solid wooden or vulcanite rings should be avoided, because during their introduction and removal they stretch the vaginal orifice unduly. Sometimes the perinæum is so deficient that the vaginal orifice is the widest part of the passage; in such a case no ring will keep *in situ*, any more than a ball could be held up in a hollow cone whose apex was upwards. We must then rely on some kind of vaginal stem-pessary, such as Napier's, held in position with perineal bands fastened to a band round the waist.

2. Cystocele and rectocele are frequently combined with *prolapse and procidentia of the uterus*; or the uterus may descend without the vaginal walls being affected, otherwise than secondarily. In any case the uterine displacement is the one which calls for treatment, and the vaginal condition will be treated incidentally, and at the same time.

For prolapse, that is, descent of the uterus within the vagina, a rubber ring usually answers best. But if the perinæum be deficient, we shall require a Napier pessary, or other vaginal stem-pessary. Sometimes the perineal bands are not well borne, as they may cause chafing and irritation; and we may then have to resort to that makeshift of therapeutic insolvency, a Zwancke pessary, or to that other refuge of the destitute, a Gariel's air-pessary. The effect of the latter is to keep the vagina in such a chronic state of distension that the natural shrinkage of the vagina incidental to the climacteric, which is looked to as the means of bringing about an ultimate spontaneous cure, is thwarted indefinitely.

For procidentia, that is, descent of the uterus outside the vagina, we have to proceed somewhat as for prolapse, with this difference, that the vaginal orifice is so stretched by the descent of the uterus that no ring will keep in at first. But, unless the perinæum has been much torn, if the patient be kept in bed for a week or so, and the uterus remains within the vagina, the orifice will usually contract again sufficiently to retain a rubber ring.

3. *Backward Displacements of the Uterus.*—This is the class of displacement most difficult to deal with. In uncomplicated cases, where the uterus is mobile, and has not been long out of place, a cure may not infrequently be obtained by means of a well-fitting Hodge pessary, or one of its modifications, such as an Albert Smith, a Thomas or a Braxton Hicks. In the two latter forms, the posterior bar, which rests in the posterior fornix, is thickened. There are various conditions, however, which make for failure. If the retroversion has existed long, the uterus may attain a condition of hyperplasia, and the heavy fundus then topples backwards over the pessary. If one or both ovaries be prolapsed, the Hodge is liable to cause such painful pressure that its use has to be discontinued. If there be cicatricial contraction obliterating the

posterior vaginal fornix, or forming bands across it, a Hodge is unavailing. I recently had such a case in the hospital, where an antero-posterior band stretched across the fornix from the apex of the cervix, and the only possible way of correcting the displacement was by ventrofixation of the uterus, which was accordingly done. If the uterus be the subject of a congenital retroflexion, we may push the organ somewhat forward, but the retroflexion will remain, and undo our work. For such a condition, pregnancy is the best cure. Lastly, if the uterus be held down by adhesions to the floor of the pelvis, pessary treatment is out of the question. I have no confidence in the plan (which has been proposed) of forcibly breaking down adhesions by manipulation; to tear a hole in the bowel by such manœuvres would not be a difficult matter.

I may say here that it is bad practice to introduce a Hodge or other pessary without first correcting the displacement, in the hope, which is a vain one, that the constant pressure of the instrument will gradually overcome the resistance. By such a course we merely add risk to inefficiency.

*Precautions to be Observed in the Use of Pessaries.*—The first thing, as I have just remarked, is that the displacement should be corrected. In selecting a pessary, some consideration should be given to the material. A non-absorbent surface is best, therefore hard rubber, vulcanite, celluloid or block tin may be chosen. The next thing is to see that the pessary is a proper fit; if too large it will cause injurious pressure, if too small it will be inefficient. But in case of doubt it is better to err in the first instance in the direction of under-size. The patient should be seen again within a week, in order that the efficiency of the pessary may be tested. A pessary tends to favour leucorrhœa, and also to retain the secretion, and therefore the patient should be instructed to use a douche at intervals. For this purpose plain water or boracic lotion is best; astringent lotions are to be avoided, because they tend to coagulate the secretion on the pessary, which thus becomes coated over with a medium highly favourable to the ubiquitous bacillus. The patient must be firmly impressed with the necessity for periodic inspection. My rule is two to three months as the longest interval. The object of the inspection is that the pessary may be properly cleaned, that its efficiency in maintaining the normal position of parts may be watched, that it may be removed when it appears probable that this can be done without a return of the displacement, and that we may have early warning of any untoward results of the sojourn of the pessary in the vagina. The importance of the last point may be judged of from what I have now to say of the drawbacks resulting from retained pessaries.

*Injuries Due to Neglected Pessaries.*—Some years ago I published some observations on this subject, and I can best illustrate my present remarks by reproducing a table of twelve cases that came under my notice.

Harm is produced in one of three ways: (a) misfit; (b) sepsis; (c) narrowing of the vaginal orifice. The precautions to be used against the first two have been mentioned. Narrowing of the vaginal orifice occurs normally after the menopause; in the case of women who are not living a conjugal life, it may become very marked, so that if a

TABLE OF CASES OF RETAINED PESSARY.

CASE.	AGE.	S M W	CONDITION FOR WHICH PESSARY WAS WORN.	VARIETY OF PESSARY.	LENGTH OF TIME WORN.	INJURY PRODUCED BY THE PESSARY.
1	64	W	"Falling of the womb"	Thick wooden ring	12 years	Purulent vaginitis; incarceration of pessary; extraction under ether necessitating tearing of vulva.
2	35	S	Not known	Vulcanite Hodge	6 months	Grooving and ulceration of left lateral vaginal fornix.
3	57	M	Procidentia	Rubber ring	4 years	Purulent vaginitis.
4	64	M	? Procidentia	Rubber ring	3 years	Purulent vaginitis; urethritis; ulcerated patch, posterior vaginal fornix.
5	30	M	Not stated	Rubber ring	1½ year	Purulent vaginitis.
6	74	M	Prolapse	Rubber ring	12 years	Purulent vaginitis.
7	72	M	Not stated	Blackbee's	8 or 9 years	Horse-shoe shaped ulcerated groove involving vaginal vault and lateral walls; vesico-vaginal fistula.
8	26	M	Retroversion	Block tin Hodge	6 months	Grooving and ulceration of right lateral fornix; fusion of edges of groove forming a band anchoring the pessary.
9	45	S	Not stated	Rubber ring	3½ years	Purulent vaginitis; excoriations of posterior vaginal walls.
10	71	M	Procidentia	Vaginal stem-pessary	6 weeks	Purulent vaginitis.
11	46	M	Retroversion	Vulcanite Hodge	3 months	Grooving and ulceration of posterior vaginal fornix.
12	45	M	Procidentia	Zwancke's pessary	"many years"	Purulent vaginitis; proliferation of granulations with formation of fibrous bands passing through the perforations in the pessary and connecting anterior and posterior vaginal walls.

pessary has been introduced and left for five or ten years it may be found impossible to remove it without a good deal of injury to the tissues of the vulva. This is what happened in Case 1. Apart from the inconveniences arising from this natural involution, the injuries produced are as follows:—The first thing is vaginitis, which soon assumes a purulent form. This may occur as a result of want of cleanliness, even when an instrument fits tolerably well; and hence it is the most common and sometimes the only condition produced by rubber rings, as in Cases 3, 5, and 6. The vaginitis may be associated with urethritis, as in Case 4. Then ulceration may supervene, either in patches, when due to a rubber ring, as in Cases 4 and 9, or in the form of a groove, in the case of a hard, narrow instrument, when localised pressure evidently plays an important part. In this way were produced the injuries in Cases 2, 7, 8, 9, and 12. The grooves become lined with granulations which tend to grow up around the pessary, and may at length grow over, partly imbedding the instrument, as in Cases 2 and 7; or may fuse, forming a bridge of tissue firmly holding the pessary to the vaginal wall, as in Case 8. Or, again, in the case of a flattened pessary with perforations, the granulations may sprout and project through the perforations, forming bands between the anterior and posterior vaginal walls, as in Case 12.

The situation of the grooving will depend on the shape and position of the instrument. In the case of a Hodge pessary, the posterior vaginal fornix is most apt to suffer. A vaginal stem-pessary will affect the tissues round the cervix. The Blackbee's pessary in Case 7 produced a quite special lesion. This instrument used to be employed for anteversion, when this was considered a pathological condition, and it rests partly in the anterior fornix,

and partly against the lateral vaginal walls; and in these positions the ulcerations had occurred. Ulceration in the anterior fornix is almost certain to lead to the serious condition of vesico-vaginal fistula, as occurred in this case. A recto-vaginal fistula might similarly result from ulceration of the posterior vaginal wall. The dangers of retained pessaries may thus be summed up as:—

- a. Purulent vaginitis.
- b. Urethritis.
- c. Ulceration of the vagina.
- d. Imbedding of the pessary in the vaginal tissues.
- e. Vesico-vaginal fistula.
- f. Recto-vaginal fistula.
- g. Incarceration of the pessary from narrowing of the vaginal outlet.

*Alternatives to the Use of Pessaries.*—We have seen that at their worst pessaries are capable of producing serious injuries; at their best they have certain inherent drawbacks. Thus there is the tendency to set up irritation, resulting in constant leucorrhœa and entailing the necessity for regular douching; there is the necessity for examination and manipulation at more or less frequent intervals, which most women naturally find very objectionable; there is the uncertainty of results; and lastly, in favourable cases there is the prospect of a woman having to wear a pessary for ten, fifteen, or twenty years.

With a mode of treatment that is open to such an indictment, it is not surprising that alternative plans have been sought. For some cases, as I have said, pessaries remain the only treatment; but there is no doubt that the modern tendency is to restrict their scope, and to regard many forms as obsolete. Pessaries were introduced when no operative radical treatment was known or practicable. Anæsthetics, antiseptics and



improved *technique* have quite altered this. It is not within the scope of these observations to embark in detail upon the question of the treatment of displacements; but in considering the uses and limitations of pessaries it is at least permissible to indicate that there is a more excellent way than theirs. Thus, most cases of prolapse of the vaginal walls can be improved or cured by perineorrhaphy and other plastic operations; and abdominal surgery provides many procedures for the definite cure of prolapse and backward displacements. Experience leads me without reserve to profess myself one of those who would fain see the use of pessaries restricted to the irreducible minimum by the substitution for them of operative measures, which do all, and more than all, that pessaries can do—without their manifold drawbacks and risks.

## THE COMPARATIVE ADVANTAGES OF INORGANIC AND OF ORGANIC IRON IN THE TREATMENT OF ANÆMIA.

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MUCH difference of opinion exists among therapeutists as to the comparative advantages of inorganic and of organic iron in the treatment of anæmia, and in this country few attempts have been made to investigate the subject scientifically. It is perhaps hardly a matter for surprise, for clinical hæmatology is still in its infancy, and experiments of this kind are liable to many sources of error. Ringer and Sainsbury point out that in some cases the astringent preparations are unsuitable, but that in most cases they produce better results than the Bland preparations of iron. This statement in a slightly modified form has appeared in many successive editions of "Ringer's Therapeutics," and it is practically certain that it is an impression derived from clinical observation and that it does not rest on the solid foundation of blood counts and estimations of hæmoglobin values.

Professor Ralph Stockman, of Glasgow, is equally positive in his advocacy of the superior value of the inorganic salts, but an examination of his admirable paper in the *British Medical Journal*, an article replete with most valuable information, shows that this was not one of the points which fell within the scope of his investigation. He records, it is true, some observations with Kobert's "hæmol" and "hæmogallol," which failed to give very encouraging results, but it is doubtful if these preparations have any claim to be regarded as true organic iron compounds or if they would respond to MacCallum's test. He proves conclusively that iron is the only drug of any value in the treatment of anæmia, but beyond that he does not go, and he records no comparative examination with different preparations of iron. Dr. C. D. F. Phillips, in the last edition of his "Inorganic Substances," is cautious in his expression of opinion, and says:—"The choice of a compound in any case of anæmia or chlorosis seems to me always to depend on the susceptibilities of the patient to the drug. Some are never able to take the astringent preparations even when the alimentary canal is not deranged." Iron, as far as we know, is the only drug of any value in the treatment of anæmia, and there is no reason to suppose that in this condition arsenic increases either the number of red blood corpuscles or the hæmoglobin value. Manganese in this connection is equally inert, and although I have prescribed it largely and in all forms, and with much success, for the relief of functional amenorrhœa in chlorotic girls, I do not believe that it

exerts the slightest influence in removing anæmia or in improving the condition of the blood. The inutility of prescribing iron with either arsenic or manganese in anæmia is obvious, for iron alone answers the purpose admirably, and the addition of another drug is superfluous.

The generally accepted view is that all forms of iron are useful in anæmia, but that they differ much in their efficacy and in the rapidity of their action. The inorganic salts are more frequently prescribed in hospital practice, whilst for private patients the Bland and less irritating preparations are the favourites. The explanation of this is simple, for it is well known that the more robust hospital patient requires larger doses of most drugs, purgatives for example, than private patients, and that the latter are more readily inconvenienced by remedies which irritate the mucous membranes of the stomach and intestines. No mere expression of opinion, however, is of much value, and the only evidence on which reliance can be placed is that founded on comparative blood examinations. It is not every case of anæmia which lends itself to this investigation. Cases of pernicious anæmia are beyond the scope of the action of iron, and are, as a rule, but little benefited by it. Cases of parasitic anæmia, such as those due to the ankylostomum duodenale, are best treated by intestinal antiseptics, although iron is useful in a later stage. The anæmias due to toxæmia, such as lead poisoning, have their specific treatment, although here again, when the existing cause has been removed, the judicious administration of iron, especially in a Bland form, proves beneficial. Anæmia, following organic change, such as cancer of the liver secondary to a primary deposit in some other organ, runs a downward course, and is not arrested by the administration of any drug. Still, there are many forms of anæmia which readily lend themselves to investigations of this nature. The best examples are the secondary anæmias of hæmorrhage, such as we get in the hæmatemesis of gastric ulcer and the chlorosis of young women, which forms so large a part of our out-patient practice. But here again a difficulty is introduced, for out-patient work is not conducive to accuracy of observation and certainly not to scientific observation. A chlorotic patient on her first visit is submitted to a blood examination, and is given a prescription for some form of iron. A week later she comes again and there is an alteration, perhaps an improvement, in her blood count and in the percentage of hæmoglobin, but there is no proof that the medicine was taken with regularity or, for the matter of that, at all. The only cases really adapted for experimental observation are those seen in private practice or in the wards of a hospital, where the administration of every dose is checked and systematically reported. Even under the most favourable circumstances there are fallacies to be avoided. A chlorotic woman is taken into the hospital, she has the benefit of rest in bed, she is placed under favourable hygienic conditions, her bowels are regulated, and she is carefully dieted. These are disturbing elements. What influence have they on the anæmia, and will they alone effect a cure? Here is a case in point:—

CASE I.—A girl, æt. 21, was admitted on October 10th, 1901, suffering from anæmia of four months' duration. She complained of general weakness, shortness of breath, and palpitation on exertion and loss of appetite. Her red corpuscles numbered 3,100,000 per c.mm., and were normal in shape and size. The leucocytes were 9,200 and the hæmoglobin value was 50 per cent. She was kept in bed, placed on a liberal diet, and constipation was relieved, but no iron was given. On October 29th, the red corpuscles were 2,687,000, and the hæmoglobin value was 35 per cent. She was more anæmic than on admission, and had made no progress towards recovery. She was then given five grains of exsiccated sulphate of iron three times a day, increased a few days later to ten grains. On November 12th, the red corpuscles were 4,900,000, and hæmoglobin value was 60 per cent. The improvement was very marked, being at the rate of 158,000 and 1·8 per cent. a day. This case shows that the patient in no way

benefited by her nineteen days' expectant treatment, and that she improved with remarkable rapidity when iron was administered.

It seemed desirable to obtain some kind of standard as to the increment of erythrocytes and daily increase in hæmoglobin value with inorganic iron, and the following cases throw some light on the subject:—

CASE II.—A housemaid, æt. 23, was admitted on May 10th, 1901, suffering from anæmia and vomiting. The patient stated that she had been ill for four years, and that she had been obliged to give up her work in consequence. Her erythrocytes numbered 3,320,000, and the hæmoglobin value was 48 per cent. She was given five grains of exsiccated sulphate of iron. On May 21st, the erythrocytes were 4,300,000 and the hæmoglobin value was 63 per cent. The increase in the red cells was at the rate of 140,000 a day and the hæmoglobin a little over 2 per cent.

CASE III.—A girl, æt. 21, had suffered intermittently from anæmia since the age of 13. She had had much treatment and was for seven weeks an inmate of a convalescent home. On admission, her erythrocytes were 1,725,000, the hæmoglobin value being only 15 per cent. She was given dried sulphate of iron three times a day, and in eleven days the erythrocytes had risen to 2,970,000, and the hæmoglobin to 36 per cent. This was at the rate of 140,000 red cells and 1.9 per cent. hæmoglobin a day.

CASE IV.—A woman, æt. 44, had been suffering from shortness of breath and swelling of the ankles for some months, so that she was unable to follow her occupation. There was no cardiac mischief, and the urine was free from albumin. The erythrocytes numbered 2,225,000, and the hæmoglobin value was 54 per cent. On the sulphate of iron treatment the blood corpuscles rose in twenty-three days to 2,875,000, and the hæmoglobin value to 61 per cent. The increase in the number of red cells was at the rate of only 29,000 a day, and the hæmoglobin 0.3 a day.

CASE V.—A girl, æt. 21, a school teacher, was admitted complaining of dyspnoea and palpitation on exertion. She had suffered from anæmia with amenorrhœa for three years. She had never had rheumatic fever, but there was a soft apex systolic murmur, probably not organic in origin. Her red cells were 3,250,000 and the hæmoglobin value was 43 per cent. It was a typical case of oligocythæmia and oligochromæmia. She was given sulphate of iron, and at the expiration of eighteen days the red cells numbered 4,450,000, and the hæmoglobin value was 55 per cent. The average daily increase was 75,000 and 0.66 per cent.

Taking the average of these five cases treated with exsiccated sulphate of iron it will be seen that the daily increase of red blood corpuscles was 103,200 and of hæmoglobin value 1.33 per cent. I have notes of other cases, in some of which the results were less striking, and I am satisfied that in ordinary chlorosis treated with sulphate of iron a daily increase of 100,000 a day with 1.3 per cent. hæmoglobin is a liberal estimate.

I made a similar series of observations with tincture of perchloride of iron given three times a day in either fifteen or twenty minim doses, with the following daily improvement:—

Case.	Erythrocytes.	Hæmoglobin.
VI.	112,500	1.33
VII.	156,000	0.30
VIII.	82,000	0.55
IX.	50,000	0.54
X.	45,000	0.53

This gives a daily average increase of erythrocytes of 89,000, and of hæmoglobin value 0.65 per cent., which is less favourable than with sulphate of iron, especially with regard to hæmoglobin. Combining the results of the sulphate of iron and perchloride of iron cases it works out at 96,000 and 0.99 per cent., or, roughly, a daily increase of 100,000 erythrocytes and 1 per cent. hæmoglobin value. This may be taken as the inorganic iron standard under favourable circumstances.

Romberg, in cases of anæmia in which the red cells

were below 4,000,000, found that the daily increase under inorganic iron treatment was not more than 43,000 with 0.99 per cent. hæmoglobin. Probably our observations were made under somewhat different circumstances, and although we are in accord with respect to the hæmoglobin, his increment of red cells is below mine.

I have had a comparatively limited experience with Bland's pill, which I regard as inferior to the dried sulphate of iron pill. Thayer states that in severe cases of anæmia when the red cells were below 2,000,000 and the hæmoglobin value was under 20 per cent., ten grains of Bland's pill three times a day increased the red cells at the rate of 107,000 a day and the hæmoglobin value at the rate of 2.7 per cent. I cannot but regard this as a very high estimate. The average duration of the treatment was twenty-eight days, which is in excess of that usually required.

Turning now to organic iron. Several preparations have recently been introduced made from spinach growing on ferruginous soil. I have had some experience of one of these, a dark green fluid with a pungent aromatic taste, due probably to the addition of flavouring agents. It is not necessary to give details, but the results worked out at 70,000 a day for the red corpuscles, whilst the increase in hæmoglobin value was small. I have also notes of cases treated with a popular blood preparation, the result showing an improvement of 86,000 red corpuscles and 1.67 per cent. hæmoglobin a day.

Probably the best of the organic iron preparations is the iron-vitellin, discovered by Dr. A. C. Barnes, of Philadelphia. This is a definite chemical product which gives a negative reaction with MacCallum's test. It is a red solution, neutral in reaction and both odourless and tasteless. I have used it not only in anæmia but in various other conditions, and it has yielded excellent results. The first test was a severe one, for the patient was suffering from cancer of the stomach.

CASE XI.—A woman, æt. 39, was admitted on April 28th, with severe hæmatemesis, apparently due to gastric ulcer, the symptoms of which were of short duration. The erythrocytes numbered 2,180,000, the leucocytes 16,600, and the hæmoglobin value was 25 per cent. She was fed by the rectum and was given an aperient iron mixture three times a day. On May 12th, there was another profuse hæmorrhage, and on the 13th a smaller one. On the 14th, the erythrocytes were 2,900,000, the leucocytes 13,200, and the hæmoglobin value was 28 per cent. She was markedly cachectic and was losing flesh rapidly. Nodules were detected on the surface of the liver, evidently malignant, and probably due to a primary growth in the stomach. She was given iron-vitellin in half-ounce doses three times a day. There was no recurrence of the hæmorrhage. On May 25th, the erythrocytes were 2,280,000, the leucocytes 14,600, and the hæmoglobin value 24 per cent. On June 1st, the erythrocytes were 2,670,000, the leucocytes 12,200, and the hæmoglobin value 30 per cent. The patient died on June 14th, and the correctness of the diagnosis was confirmed at the autopsy. In a case of malignant disease running a downward course no marked improvement could have been expected from any drug, but there was no recurrence of the hæmorrhage and there was some increase in the percentage of hæmoglobin.

The following case was more successful and gave excellent results:—

CASE XII.—The patient was a housemaid, æt. 17, who had been suffering from chlorosis for six months, for which she had had much treatment without benefit. On June 2nd, her red corpuscles numbered 2,410,000, and her hæmoglobin value was 40 per cent. She was placed on iron-vitellin three times a day, and on June 8th, the red cells were 4,230,000, the hæmoglobin value being 42 per cent. She had menstruated during the time. The increase in red cells was at the rate of 303,000 a day, and hæmoglobin value 0.33 per cent. Although diminution in hæmoglobin value is the essential feature of chlorosis, there is, in many cases,

a decreased number of erythrocytes, and the red cells are small and irregular in shape.

The next are similar cases:—

CASE XIII.—A girl, *æt.* 23, complained of frontal headache, general weakness, and lassitude and dyspnoea on exertion. The bowels were obstinately confined and the catamenia had been absent for four months. The conjunctivæ, lips, and nails were pale, and the condition was obviously due to anæmia. She had taken Bland's pill in five-grain doses three times a day without any amelioration of the symptoms, but with increased constipation, the bowels acting only every four or five days. The accumulation of fæces was removed by the administration of five grains of calomel, after which she was given half-ounce doses of the iron solution three times a day. There was an immediate improvement in her general condition, and in three weeks her red cells increased from 2,850,000 to 4,782,000, being at the rate of 92,000 a day. The hæmoglobin value increased from 52 to 70 per cent., being at the rate of 0.85 per cent. a day.

CASE XIV.—The patient was a woman, *æt.* 26, whose blood was examined at intervals of four days for a fortnight. The initial count showed erythrocytes 2,260,000, with hæmoglobin value 56 per cent. At the second examination the red cells were 3,400,000, with hæmoglobin 62 per cent. Four days later they numbered 4,200,000, and the hæmoglobin value was 68 per cent. At the final examination at the expiration of fourteen days the red cells were 4,480,000, with hæmoglobin value 76 per cent. In this case the rise was at the rate of 158,000 a day and hæmoglobin 1.6 per cent. The iron solution was given in half-ounce doses three times a day.

The next case belongs to a different category:—

CASE XV.—A governess, *æt.* 30, suffered from anæmia, the result of a prolonged attack of rheumatic fever with mitral regurgitation. She was breathless and incapable of much exertion. Her erythrocytes numbered 3,450,000, and her hæmoglobin value was 43 per cent. She was given iron-vitellin for ten days, and at the expiration of that period the red cells were 4,500,000, with hæmoglobin 62 per cent. Her subjective symptoms had disappeared, her appetite had improved, and she was able to take a fair amount of exercise. The erythrocytes had increased at the rate of 105,000 a day, and the hæmoglobin value 1.9 per cent. a day. The iron-vitellin in this and other cases apparently exerted a general tonic action quite apart from its influence on the blood constituents. In two cases in which, although the patients were markedly debilitated, the erythrocytes numbered over 6,000,000, an improvement in tone and in the general condition of the health followed its administration. It seems to be useful in those anomalous cases of anæmia such as are met with in children in which diminution in the number of red cells, and even of hæmoglobin value, is not the predominant factor.

The next was a case of secondary anæmia:—

CASE XVI.—A woman, *æt.* 28, was anæmic as the result of a profuse hæmatemesis due to gastric ulcer. For some weeks she had complained of pain referred to the pyloric end of the stomach following each meal. There was only one attack of bleeding, and it was difficult to estimate the amount, although apparently it was profuse. The family history was not good, the mother having died of malignant disease of the uterus. On the day following the hæmatemesis the erythrocytes numbered 3,260,000, the white cells were 6,500, and the hæmoglobin value was 50 per cent. The patient was kept in bed in a recumbent position and was given three pints of milk in the twenty-four hours. The bowels were kept well open, and half an ounce of the iron solution was ordered three times a day. There was no return of the bleeding, and at the expiration of ten days solid food was taken without difficulty. The erythrocytes then numbered 4,460,000, the white cells were 7,500, and the hæmoglobin value was 70 per cent. The daily increase of red cells was 120,000 a day with 2 per cent. hæmoglobin.

The last case belongs to a type which is by no means uncommon:—

CASE XVII.—A man, *æt.* 53, complained of want of energy and general weakness with shortness of breath on exertion, especially on going upstairs. For many years he had led an active life mentally, but had taken very little physical exercise, rarely walking more than half a mile a day. He was a free liver, and took three good meals a day with a plentiful allowance of alcohol at lunch and dinner, usually in the form of champagne, with an occasional glass of port and whisky in the evening. He had put on flesh, but his muscles were flabby and the superficial veins of the face and nose were enlarged and congested. He was emphysematous and suffered from a chronic cough, kept up by incessant smoking. He was in a nervous and irritable condition, and slept badly. His arteries were hard and the heart was dilated, although there was no murmur. The liver was enlarged, and there was a trace of albumin in the urine. The bowels were confined, but were relieved from time to time by large doses of an aperient bitter water. His red corpuscles numbered 2,750,000, and the hæmoglobin value was 38 per cent. He was kept in bed, his alcohol was knocked off, and he was given three pints of milk and a pint of beef-tea a day. The bowels were kept freely open with sulphate of magnesium, and an ounce of iron-vitellin was given three times a day. At the expiration of ten days he had materially improved, the albumin had disappeared from the urine, his tongue was clean, he slept better, and expressed a strong desire for food. His erythrocytes had increased to 4,400,000, the leucocytes had fallen to 9,500, and the hæmoglobin was 47 per cent. The daily increase in the erythrocytes was 165,000, and hæmoglobin value 0.9 per cent.

Excluding the first of these cases, which was obviously unsuited for treatment, we find that under the iron-vitellin treatment the daily increase in erythrocytes was 157,000, and the hæmoglobin percentage 1.26. This, with regard to the red blood corpuscles, shows an improvement of 50 per cent. over the best inorganic iron treatment, and with regard to the hæmoglobin value a gain of 25 per cent.

These observations are admittedly incomplete and merely touch the fringe of the subject, but they show that a good organic iron preparation compares favourably with the best of the inorganic salts apart from the great advantage of being easily assimilated and free from the discomforts which so frequently attend the administration of the astringent forms of the drug.

### ABSTRACT OF The Cavendish Lecture

ON  
EXPERIMENTS ON THE IMMUNISATION  
AGAINST INFECTION OF OPERATION  
WOUNDS, ESPECIALLY OF THE  
PERITONEUM. (a)

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MR. PRESIDENT AND GENTLEMEN,—The successful treatment of infectious diseases to-day involves in many cases a combination of the two methods of treatment discovered, the one by Edward Jenner and the other by Lord Lister. Hygienic measures based upon Listerian principles attempt to exclude or render harmless the cause of infection, whilst specific preventive inoculation endeavours to render individuals more capable of resisting infection. Surgery has made but little use of the principle of preventive inoculation because the multitude of pyogenic micro-organisms which may infect the wound adds greatly to the difficulty of finding a practical method of inoculating against them. The immunisation of wounds does not press with the urgency of general infectious diseases because

(a) Delivered before the West London Medico-Chirurgical Society June 24th, 1904.

the majority of wounds are efficiently guarded from infection by antiseptic treatment. There are, however, many operations in which the principle of antiseptics becomes useless because the affected tissues or organs, owing to their physiological properties or their pathological conditions, are invaded by pathogenic organisms. The problem of effectually disinfecting the mucous membrane of the stomach and intestines in preparation for operation has not yet been solved. We possess, it is true, a number of technical expedients for limiting the danger of infection, but they do not succeed with certainty in preventing it in every case. The dangerous peritonitis in serious operations on the stomach and intestines is due to the fact that the bacilli from the intestines escape in too great a number to be tolerated by the peritoneum; that is to say, the natural power of resistance of the peritoneum in the individual is not sufficient to overpower the mass of bacteria introduced. We can diminish the danger of peritonitis at the present time only by increasing the power of resistance of the peritoneum against intestinal bacteria. One means of effecting this is by producing an artificial hyperleucocytosis. Loewy and Richter were the first to try by the injection of albumoses, especially spermin, into animals to produce a hyperleucocytosis and thereby to make the animals capable of resisting infection of pneumococci. In a similar way Jakob, by intravenous and subcutaneous injection of albumose into rabbits, made them proof against pneumococci and mouse septicæmia. After each injection a hyperleucocytosis occurred first and later a hyperleucocytosis. If the infection was brought about during hyperleucocytosis the animals without exception died. On the other hand, the course of the disease was influenced in the most favourable way when the infection was introduced after a hyperleucocytosis had occurred, and was still increasing. Hahn succeeded in showing that during that stage of hyperleucocytosis the blood of men and dogs possessed a higher bactericidal value than normal blood. Hahn used yeast nuclein in his experiments on dogs and tuberculin in those on man. These experiments do not seem to have led to any practical result in the case of man. At any rate, Goldscheider did not entertain great hopes of the therapeutic value of hyperleucocytosis. More recently Hofbauer, in Vienna, has obtained favourable results in undoubted puerperal septicæmia by the administration of from five to six grammes of nuclein by the mouth. The slight therapeutic value of artificial hyperleucocytosis in disease which has already made itself evident—as, for example, in pneumonia—can be readily understood. The infected organism is at the time of the application of the remedy overpowered by the pathogenic microbes; all the engines of defence of the organism have already had to be led into the field. A still further increase through a later artificial hyperleucocytosis cannot be expected.

The question arises whether artificial hyperleucocytosis may not be of value in practice as a prophylactic. According to the above-mentioned experiments one cannot exclude the possibility that by a partly anticipated mobilisation of great masses of leucocytes the latter may overcome the bacteria which have obtained entrance in the first instance in relatively small masses with greater ease than if the leucocytes delay their attack in force until the number and virulence of the bacteria in the tissues have markedly increased. Whether the observations of Jakob are applicable to the peritoneum had to be established by experiments on animals before they could be used upon man. Dr. Miyake, of Japan, who recently worked in my clinic, undertook at my suggestion these experiments upon animals. These were carried out in the Breslau Hygienic Institute under the control of Professor Flügge. We already had a predecessor named Salieri, who, in 1902, carried out experiments to increase the resistance of the peritoneum against bacillus coli infection, and found that with small quantities of normal saline solution he could increase the natural resistance in guinea-pigs by sevenfold to sixteen-fold. The experiment was made three times on man in cases of

laparotomy in which Salieri injected from 30 to 60 cubic centimetres of saline solution into the abdominal cavity. Salieri believed that he obtained favourable results, but in my opinion the operations carried out by him do not definitely demonstrate an increased resistance of the peritoneum. Salieri was led to undertake his investigation by the well-known experiments against cholera conducted by Issaëff, in 1894. Issaëff produced in guinea-pigs hyperleucocytosis in the peritoneal transudate by intraperitoneal injections of normal saline solution, of bouillon, of nucleic acid, and of tuberculin. At the summit of this hyperleucocytosis he injected virulent cholera vibrios into the peritoneum and noted, according to the nature of the injected fluid, a more or less marked increase in the resistance of the peritoneum to the injected cholera bacilli. The most powerful reaction was obtained with nucleic acid. With an injection of one cubic centimetre of a 2 per cent. solution of nucleic acid the peritoneum was able to withstand from 13 to 17 lethal doses of cholera vibrios. Issaëff observed that the destruction of the microbes was carried out by the leucocytes of the peritoneal transudate. After only two hours the phagocytosis was evident. In the third hour free micro-organisms could no longer be found in the exudate and after five hours the process of destruction of microbes was completed. Just as Issaëff used guinea-pigs for his experiments, we, too, selected that animal. Although the prospects of a satisfactory specific active immunisation of man against the virus of peritonitis, as has been explained, are extremely small, nevertheless we made experiments in this direction first, for in guinea-pigs the conditions are much more favourable. The bacilli coli alone are markedly pathogenic for the peritoneum of the guinea-pig, whilst the other co-excitors of peritonitis in man, especially the streptococcus and staphylococcus pyogenes, are almost entirely harmless to guinea-pigs. The experiments were carried out in this way. From half a loopful to two loopfuls of a sterilised culture was injected into the peritoneum from a strain of bacillus coli. After a definite interval, which was different in different experiments, had elapsed, the animals tolerated the introduction of five loopfuls of living virulent culture and also the escape of the contents of the intestine into the abdominal cavity. The active immunisation with a strain of bacillus coli (derived from man) was thus, we may presume, able to protect against other bacillus coli strains that were accidentally present in the contents of the intestine. Nevertheless, it is possible to come across by chance strains in the case of which this does not occur. That in man we have to reckon not only with different strains of bacilli coli, but also with different strains of streptococci and other pathogenic bacteria, has been demonstrated above. On these grounds we did not make any further experiments for obtaining a specific active immunisation even of guinea-pigs. The further experiments consisted exclusively in producing a general increase in resistance by hyperleucocytosis. In accordance with the procedure of Issaëff we tried the injection of various fluids into the peritoneal cavity; later, subcutaneous injections were also tried, for this form of application is better adapted to man than that of intraperitoneal injections. Sodium chloride solution (0.85 per cent.), neutral bouillon (2 per cent.), starch in physiological salt solution, and nucleic acid were used for injection. The first three solutions were only used intraperitoneally, nucleic acid subcutaneously as well. For intraperitoneal injection 2 per cent. of nucleic acid was used, for subcutaneous injection 5 per cent. neutralised nucleic acid solution; one cubic centimetre of the solution was injected per 250.330 grammes bodyweight. We found, in agreement with earlier experimenters, that the intraperitoneal injections of normal saline solution in the quantities above mentioned gave rise to a marked hyperleucocytosis in the peritoneal transudate. The maximum was reached after from 17 to 18 hours with an increase to about fourfold the normal leucocytosis. Still greater was the effect when the peritoneal cavity was washed out with 50 cubic

centimetres of normal saline solution; in this case about two-thirds of the solution was left in the cavity. Maximum hyperleucocytosis occurred after 24 hours and resulted in five times the normal number of leucocytes. The reaction due to neutral bouillon was much less marked than that of normal saline solution. But a far more energetic action followed the 2 per cent. aleuronat mucilage. The maximum peritoneal hyperleucocytosis occurred in 30 hours and rose to between seven and eight times the normal number. A similar result followed the use of nucleic acid, but the reaction was more speedy. The maximum was between seven and eight times the normal, and occurred eight hours after the injection. Along with the local, general leucocytosis in the blood took place but to nothing like the same extent. The maximum in one case was double the normal number of white cells. Subcutaneous injection also of 5 per cent. nucleic acid led to a hyperleucocytosis in the peritoneum, as well as in the blood. The latter reached almost to the same height as with the injection in the peritoneum, the former remained far below. It reached approximately two and a half times the normal number. The important point is that here also, as in the experiments of Jakob, the injection caused a hypoleucocytosis in all cases after half an hour to one and a half hour. With normal saline solution and with bouillon it was not considerable; with aleuronat and nuclein it fell even to one-tenth of its original amount in the peritoneal transudate. No general disturbance of any importance occurred. With the injection of normal saline solution the temperature was scarcely raised; with aleuronat and nucleic acid there was a rise of from  $0.5^{\circ}$  to  $1.5^{\circ}$  during the first hours after the injection.

After these experiments we used the injection with the above-mentioned fluids as a preliminary to an infection of the peritoneum, and in the first instance a strain of bacterium coli was employed, which we found to be very virulent for guinea-pigs. After it had been ascertained by eleven test experiments that the minimum lethal dose was a quarter of a loopful, the prepared animals were infected with the same strain. The infection of the peritoneum followed regularly seven hours after the preparatory treatment, and therefore at a time when the hyperleucocytosis had not yet quite reached the maximum. The result was as follows:—The effect of a single injection into the peritoneum of one cubic centimetre of normal saline solution was relatively weak, the power of resistance being only doubled (the infection after washing out the peritoneum with saline solution could not be employed because the bacillus coli strain at the time of the experiments in question had already lost its virulence). Much more energetic was the action of the intraperitoneal injection of aleuronat, since it increased the resistance of the peritoneum eightfold. Nucleic acid was still more active, for with this the power of resistance of the peritoneum was raised from sixteen to twenty-fold. The subcutaneous injections of 0.5 per cent. neutralised nucleic acid similarly increased the power of resistance of the peritoneum from sixteen to twenty-fold. Distinctly weaker was the action of a 0.25 per cent. solution. The effect of repeated intraperitoneal injections of nucleic acid was considerably stronger. In this manner the resistance of the peritoneum could be raised to forty times the normal. Repeated subcutaneous injections of nucleic acid led to 32 times the normal resistance. I may note in passing that none of the fluids used for injections in the neutralised form had any bactericidal action upon the bacterium coli selected for injection. It would have been very desirable to carry out the same series of experiments against the other bacteria that collaborate in the production of peritonitis in man, and, above all, against the streptococcus and staphylococcus aureus and albus. Unfortunately, we found, in agreement with other people's observations, that the streptococci and staphylococci isolated from patients in our clinic were non-virulent for guinea-pigs. We therefore tried experiments upon rabbits, but the same difficulty arose. It is not easy to find a strain of

staphylococci which has a pathogenic effect on the peritoneum of the rabbit. We can definitely assume from the experiments of Kiskalt that in combating the staphylococcus pyogenes both leucocytosis and the destruction of the bacteria by the method of phagocytosis play at least as important a part as when the fight is between the organism and the bacterium coli. So far as the streptococcus is concerned the strains isolated from our clinic were insufficiently virulent for the peritoneum of the rabbit. One of the strains of the streptococcus given to us by Dr. Aronson, of Berlin, was, it is true, virulent for rabbits, but to such a great extent that it acted as a specific bacterium of these animals. Against these highly virulent specific bacteria little effect is, as we already know, produced by a general increase of resistance by hyperleucocytosis. In these cases only a specific immunisation is of avail against infection. For these reasons the experiments could not be carried out in the way referred to. On the other hand, the experiments upon bacilli coli were supplemented in a most satisfactory manner by a series of observations which simulated the natural conditions occurring in peritonitis due to perforation. The experiments consisted in performing a laparotomy and forcing through an opening in the stomach or intestine as much of their contents as could be obtained from the immediate neighbourhood of the incision. Of five control animals which had not been previously prepared four died from peritonitis between five and sixteen hours after the operation. The fifth became extremely ill but finally recovered, but the amount of intestinal contents which was transferred to the peritoneum was less in this case than in the others. Ten animals were prepared. These recovered without exception. The preparation consisted in three intraperitoneal injections of nucleic acid, two injections of sterilised bacteria coli, three more injections of nucleic acid into the peritoneum, and two subcutaneous injections of neutralised nucleic acid. In each case laparotomy was performed seven hours after the injection. These experiments are such as to excite our interest in the highest degree, for by subcutaneous injections of nucleic acid it was possible to raise the resistance of the peritoneum to such an extent that even a considerable quantity of intestinal contents could be placed in the peritoneal cavity without causing damage, whilst without previous treatment an acute, rapidly fatal peritonitis followed almost without exception. This opens out a new field for the surgeon in preventing post-operative peritonitis. On three more animals a therapeutic experiment with neutralised 2 per cent. nucleic acid was tried. This solution was injected subcutaneously some time after the injection of the peritoneum with bacilli coli. It was found that when the infection had preceded the injection by six hours the peritoneum was able to stand only four times the lethal dose; whilst if the infection had taken place only one and a half hour before, then the animal was able to withstand eight times the lethal dose. One animal which received twelve times the fatal dose along with the nucleic acid injection succumbed nineteen hours after the infection. It therefore follows that subcutaneous injection of nucleic acid, if not used at too great an interval after the peritoneal infection, possesses a definite therapeutic value. This observation may perhaps be of value in acute cases of peritonitis from perforation.

I felt justified after these promising experiments upon animals in beginning similar experiments, safeguarded by every precaution, upon man. We first tried a  $\frac{1}{2}$  per cent. solution of the neutralised nucleic acid, and gradually increased the strength up to 4 per cent. As a rule, 50 cubic centimetres of the solution were injected subcutaneously. Intraperitoneal injection was tried in one case; and that the very first, but this method was entirely relinquished owing to its difficulty and the trouble it gave the patient. The 4 per cent. solution was injected twice. Thenceforth we always used the 2 per cent. solution, so that an adult man received about one gramme of nucleic acid to 75 kilogrammes of bodyweight. In all, 58 cases were treated in this



way. In 55 cases the operations were upon the stomach, intestine, or other abdominal viscera, and in three cases for extra-abdominal disease. In four cases the operations did not take place until more than 34 hours after the injection was given. We have thus on four occasions had the opportunity of observing the effect of the injection by itself. After the subcutaneous injection of neutralised nucleic acid we have constantly observed, not only in animals but also in man, a hyperleucocytosis in the blood which was almost always preceded during the first hour or so by a hypoleucocytosis. The question how high a degree of hyperleucocytosis was obtained through the injection is difficult to answer on the basis of our observations. We are not in a position to make any definite statements as to the beginning of the most favourable phase of hyperleucocytosis because the operation was, in the great majority of cases, apparently performed before the commencement of this phase. Only in five cases was there a distinct fall in the hyperleucocytosis before the operation; in one of these it occurred between 13 and 19 hours after the injections. The operations were performed in four cases from five to six hours, in nine cases from nine to twelve hours, and in twelve cases from 13 to 19 hours after the injections. The experiments on guinea-pigs showed that the optimum for nucleic acid was reached seven hours after the injection. It seems to occur in man considerably later. We have therefore recently fixed the interval between preventive injection and operation at 12 hours. We believe that we thus, as a rule, follow out the instructions to operate on the rising tide of leucocytosis.

As regards the phenomena accompanying the injection of nucleic acid, no serious local or general symptoms have as yet come under our observation. In the two cases in which a 4 per cent. solution had been injected the sensation of giddiness lasted but a short time. The most unpleasant factor for the patient is the local reaction. A tenderness and a slight swelling around the point of injection remain, as a rule, throughout the day. An intense erysipelas-like redness in two cases was seen, and it disappeared without leaving any trace after 24 hours. The only sign of reaction which appears with regularity is a slight increase in the temperature, which may be observed during the first few hours after injection ( $99^{\circ}$  to  $100^{\circ}$ ). In five cases the temperature remained below  $98.6^{\circ}$ , in 27 cases it rose to  $100^{\circ}$ , in six cases to  $101^{\circ}$ , in three cases to  $102^{\circ}$ , and in three cases above  $102^{\circ}$ .

You will now ask me how far the immediate object of the injection of nucleic acid was attained, and how far the preparation of the cases had a favourable effect upon the course of the operation. In ten cases of resection of the stomach for carcinoma nine recovered, six of them without the slightest complication. The progress was marked by a smoothness that was quite exceptional before this treatment was adopted. Two cases which presented exceptional difficulty in the removal of the carcinoma did undoubtedly within 24 hours develop peritonitis with a pulse up to 160, which according to our usual experience foretold the most dismal prognosis. The patients fortunately survived this peritonitis. In the ninth case which recovered the progress was disturbed from the fourth day by broncho-pneumonia. The tenth case died; after seven days of uninterrupted progress he developed pneumonia, to which he succumbed three weeks after the operation. Of the remaining operations I should like to refer first to 22 cases of gastro-enterostomy and entero-anastomosis, 12 of which were for carcinoma. Of these cases 19 recovered and three died. In all three cases death was most certainly not due to post-operative peritonitis, but in one case to perforation of an ulcerated carcinoma of the stomach two weeks after the operation, in another case to continued hæmorrhage from a carcinoma of the stomach 16 days after the operation, and in the third to peritonitis arising from a tuberculous granuloma in the intestine four weeks after operation. Of six cases of resection of the intestines at one operation four recovered and

two died. In one case death occurred from collapse on the second day after a very prolonged operation of double resection for carcinoma; in the other case, where the injury was a bullet wound, death took place on the tenth day from hæmorrhage from the vena cava. In neither of the cases was there any peritonitis. One case of opening the stomach and stretching the cardiac orifice, performed on account of spasm, recovered. So also did six cases of operation on the bile-duct, seven other operations upon abdominal organs without opening the intestinal tract, and three extra-abdominal operations. The last to be mentioned are two cases of nephrectomy which were treated before the operation with nucleic acid. In both cases in order to remove the suppurating kidney the peritoneum had to be widely opened. One case recovered; the other died 12 days after the operation from hæmorrhage from the renal artery. In this case, too, there was no peritonitis. We therefore have 45 laparotomies in which the abdominal cavity was exposed to infection by the contents of the stomach or intestines or by some other infectious secretion. Of these cases 38 recovered and in none of the seven fatal results was peritonitis the cause of death.

While relating my clinical experiences, I have referred to nucleic acid only as a method of producing leucocytosis, but we have also used in most cases, and especially in severe operations upon the stomach and intestines, a second means which, according to experimental observations, is able to increase considerably the power of resistance of the peritoneum—I mean the intraperitoneal infusion of normal saline solution. Departing from my earlier practice I have used more and more during the last two years free irrigation of the peritoneal cavity with warm normal saline solution in all laparotomies in which the peritoneum runs some risk of infection.

## Transactions of Societies.

### SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, MAY 27TH, 1904.

MR. WALTER EDMUNDS, F.R.C.S., in the Chair.

*A Case of Multiple Sarcomata of the Scalp* in a child, æt. 2, was shown by Mr. WILSON for Dr. EDMUND CAUTLEY. In September, 1903, the right eye had been excised for glioma. One month previously lumps had been noticed on the head, which had grown rapidly. At present the new growths were numerous, large, and scattered over the scalp. There was also evidence of involvement of the left eye, and a purple discoloration of the eyelids on both sides was present. The face was of a waxy pallor and œdematous.

Mr. GEORGE PERNET described a case of multiple sarcomatous growths in the skin in which the right eye was bulged forward, presumably from a primary growth behind it.

*A Case of Tumour Occupying the Left Half of the Abdomen*, in a girl, æt. 6, was shown by Mr. FRANCIS JAFFREY. She had suffered from pain in the left side of the abdomen, hæmaturia, and difficulty in micturition. The tumour was smooth and elastic, did not fluctuate, and was fairly movable. He was of opinion that it was a case of sarcoma of the left kidney, and asked as to the advisability of operative treatment.

Mr. WATSON CHEYNE agreed with the diagnosis, but thought that complete removal could not be looked for, as the pedicle of the kidney seemed to be involved.

Mr. CLEMENT LUCAS thought that, as the case was probably hopeless if left alone, an effort might be made to remove the tumour if possible.

The CHAIRMAN (Mr. Walter Edmunds) thought that an exploratory incision might be employed to determine whether the tumour was removable or not. He asked for particulars as to history of such cases after operation.

Mr. THOMSON WALKER said that an increasing

number of renal tumours were removed from children with immediate good results, and with a good after-history, namely, of three to five years in which no recurrence had taken place. Each case must be taken on its own merits, and if the tumour were examined from within the abdomen there would be a better chance of ascertaining whether it was removable, and whether there was likely to be a recurrence.

*A Case of Status Lymphaticus* was described by Mr. HUNTER TOD. An infant, *æt.* 6 months, had been the subject of laryngeal stridor and died suddenly. Dr. WALTER EMERY showed the organs from this and another infant affected with the status lymphaticus. There was an enlargement of practically all the lymphoid tissues of the body, including the thymus, the glands (especially the mesenteric), the solitary follicles and Peyer's patches in the intestine, the tonsils, and the adenoid tissue of the naso-pharynx. The spleen and tongue were normal, the latter not showing enlargement of the circumvallate papillæ, which had sometimes been described as of diagnostic value. The thymus gland weighed almost exactly an ounce in each case, but there was no evidence of direct pressure on the vagus, the trachea, or the heart. He drew special attention to the marked thickening in parts of the intestinal wall from the overgrowth of lymphoid tissue.

Dr. E. P. BAUMANN confirmed this observation. He had seen two fatal cases, one an infant, *æt.* 3 months, and the other *æt.* 9 months. The first infant was brought to the hospital in a state of great respiratory embarrassment, cyanosed, and uttering peculiar respiratory sobs. Death soon ensued, and the thymus was found to weigh four and a half ounces. It lay chiefly on the right side, pressing on the heart, and it might also have pressed on the trachea, causing death directly from suffocation.

Mr. THOMSON WALKER said this was a very important subject, not only from the medico-legal point of view, but also from the surgical. One writer had collected ten cases in which death had occurred, at the commencement of chloroform administration, or during it, or immediately after the operation. In addition to the other changes mentioned, a hyperplasia of the arteries had been noted, leading to narrowing of the lumen.

Dr. EMERY, in reply, said that one could not absolutely exclude pressure on the trachea from the post-mortem findings. The thymus might suddenly become engorged with blood and exert direct pressure on the trachea, and all signs of this might have passed off before the post-mortem examination.

*A Case of Tuberculous Periostitis* was shown by Mr. LOCKHART MUMMERY. There was a fluctuating swelling on the middle finger of the right hand, and the right radius and right cheek were also the seats of tuberculous growths.

*A Case of Paralysis of the Left Trapezius Muscle following an Attack of Herpes* was shown by the CHAIRMAN (Mr. Walter Edmunds). The patient was a girl, *æt.* 6, who, three weeks after an attack of herpes affecting the skin over the left shoulder and the upper part of the left scapula, was found to have "winging" of the left scapula. This was found to be due to weakness of the left trapezius muscle, which responded neither to galvanism nor faradism.

*A Case of Achondroplasia*, in a boy, *æt.* 12, was demonstrated by Mr. HAROLD BALME. As usual in this affection the membrane bones were unaffected, while all the long bones showed marked shortening.

Mr. A. D. REID showed a series of skiagrams of this patient, with the following abnormal features: (1) The ends of the diaphyses were expanded; (2) both humeri were bowed; (3) there was a lateral curve in the left tibia and fibula; (4) the ends of the diaphyses of the long bones were notched; and (5) the phalanges were short and broad.

*A Case of Tuberculous Disease of the Elbow-Joint, with Dislocation of the Upper End of the Radius*, in an infant, *æt.* 15 months, was shown by Mr. J. THOMSON WALKER. Three months after a fall the elbow had become swollen

and tender, and the child was treated at another hospital for fracture about the elbow, the arm being put up in splints, and later massage was used. Under this treatment the arm got steadily worse. Mr. Thomson Walker found the ends of the humerus, radius, and ulna to be markedly thickened, and the joint swollen. There was also thickening of the fifth metacarpal bone of the left hand. As regards the diagnosis, he had to consider whether a fracture had ever been present, and whether syphilis might not be a factor in the case, as there was a history of numerous miscarriages. Under mercurial inunction and splinting the condition had almost entirely cleared up after four months. The patient then passed from observation, and some months later the joint was found to be much worse, and the upper end of the radius was dislocated forwards. Later there was definite evidence of tuberculosis in the joint.

*A Girl, æt. 2, with Motor Paraplegia and with Absence of Speech, which might have been Congenital, or Syphilitic, or Secondary to Scarlet Fever and Diphtheria*, was exhibited for diagnosis by Dr. EWART. He demonstrated a method of using the reflexes (superficial and deep) as a means of exercising paralysed muscles, which he had not previously published.

A paper on *A Case of Perforated Gastric Ulcer* in a boy, *æt.* 13, was read by Mr. WATSON CHEYNE and Dr. R. H. W. WILBE. The patient had enjoyed good health until the onset of the illness, which was marked by severe abdominal pain about the umbilicus. He rapidly became worse, and after consultation the same evening it was decided to operate. The appendix was examined, found to be diseased, although not actively, and was removed. As the signs pointed to some rupture, the rest of the abdomen was explored, and over the front of the stomach some turbid fluid was found, and gas bubbled up. On further searching, a small, round perforation was found on the anterior surface of the stomach about an inch from the cardiac end, from which gastric juice and gas were escaping. The ulcer was treated in the usual way, and the boy made an uninterrupted recovery. They referred to the rarity of perforating gastric ulcer, apart from tuberculosis, at this age. Another point of interest was that a diseased appendix was found and removed, but the presence of gas in the abdomen showed that there must be some other lesion. Unless this sign had been regarded as conclusive they would not have discovered the ulcer, for its situation was so remote that every part of the intestines and stomach had been previously examined, and very careful searching was required to find it.

Mr. CLEMENT LUCAS was not quite sure from the history of the case that tuberculosis could be excluded as the cause of the ulcer. The condition was certainly a very rare one.

Dr. PORTER PARKINSON referred to a case he had met with in a child of two years, where death was due to a perforating gastric ulcer, and where post-mortem no trace of tuberculosis could be detected in any part of the body.

## Special Articles.

BRITISH SANATORIA FOR CONSUMPTION.—  
XLIII.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

THE DARTMOOR SANATORIUM, CHAGFORD,  
DEVON.

DEVON'S famous highlands, Dartmoor, has long been a favourite resort of the artist and the antiquary, and a happy hunting ground for the sportsman, but its possibilities as a health station have received but little serious study. Various well-known resorts in Devon have been widely advocated and extensively used as residences for the consumptive, but it is a somewhat remarkable fact that at present there are only three sanatoria, one public and two private,

where efficient and systematic open-air treatment is provided in accordance with modern procedure. Dartmoor, particularly in the neighbourhood of its marginal fringe, offers climatic and geographical conditions peculiarly suited to the needs of many phthisical cases; and Chagford, on its eastern border, furnishes a locality almost ideal for the hygienic management of many patients with pulmonary tuberculosis. Dr. A. Scott Smith has, therefore, shown wise discernment in establishing his Dartmoor Sanatorium at Torr House, on the eastern slopes of Devon's tableland, at an elevation of about 750 feet above sea level, and about a mile and a half above and to the west of the charming hamlet of Chagford, 19.3 miles distant from London, and situated at an altitude of 650 ft. We have thoroughly explored the district and have carefully inspected the sanatorium, and have had the privilege of a personal study of the manner and method of management there employed, and are thus able to testify not only to the local advantages of the district, but can also bear witness to the very efficient and scientific conduct of the treatment.

Dr. Scott Smith is himself an old tuberculous patient who has had wide experience of sanatorium management. He is an ardent disciple of Walther, and his establishment is conducted on strict Nordrach lines, but softened by a sympathy which is characteristic of the best in English medicine, and strengthened by a sound common sense which must appeal to all unfortunate Britishers fortunate enough to come under Dr. Scott Smith's firm and far-seeing control.

The sanatorium is particularly well placed, sheltered by hills and trees from trying winds, freely open to the south and immediately surrounded by attractive grounds. The institution has been fitted for its purpose by a wise adaptation and modification of a large and well-constructed private country house. The patients' rooms have been furnished in accordance with modern demands. The dining-room is a large, airy and well-lit apartment. The house is provided with electric light; the drainage system is excellent, and there is a plentiful supply of water both for baths and drinking purposes.

At the present time the establishment is being enlarged by the addition of several admirably designed rooms.

Dr. Scott Smith, as we have had ample opportunities of observing, devotes himself entirely to the direction of his sanatorium. Every case is constantly under his supervision, and each detail of the patient's life is subjected to medical direction. Great care is given to the nutrition of the sufferers, and hyper-alimentation is rigorously enforced. The amount of exercise and rest is carefully regulated. The walks are peculiarly attractive, numerous, and in gradient, degree of protection and exposure allow of great variation. We consider the sanatorium almost unique among English institutions in the excellence of its facilities for picturesque and suitable pedestrian exercise. Other forms of exercise are wisely discouraged, and patients are not advised to spend time in shelters. They are thoroughly instructed in the hygienic management of their disease. The fear of chills from exposure or the dangers supposed to arise from getting wet are demonstrated to be in great measure mythical. No systematic medication is employed.

The sanatorium is placed in a truly romantic neighbourhood, embracing some of the finest river, mountain and moorland scenery in England. Opportunities for hill-climbing lie close at hand, and tors ranging from 800 to 1,400 feet are within easy reach. Patients with artistic tastes will find endless material for brush or pencil in the perfect river peeps on the South Teign, along the banks of which suitable cases can freely ramble. We consider the psychical influence of the district to be one peculiarly advantageous to phthisical patients of refined tastes and artistic inclinations.

It should be added that Dr. Scott Smith and his wife take all their meals with the patients, and lead the same open-air life. The maintenance of English

home life is an element the advantage of which patients are not slow to appreciate.

The terms depending on the room occupied are from three to five guineas per week, inclusive of medical attendance, board and lodging.

The sanatorium is by no means so inaccessible as might be thought. A carriage can be sent to meet patients on arrival at either of the two available railway stations, *viz.*, Moretonhampstead (G.W.R.), five miles off, or Okehampton (L. & S.W.R.), eleven miles distant.

Moretonhampstead can be reached from London *via* Exeter and Newton Abbott in about five and a half hours; and Okehampton *via* Exeter in about four and a half hours. During the summer months, by leaving Waterloo at 11 a.m. Okehampton may be reached at 3.12 p.m.

Omnibuses under the direction of G.W.R. run from Moretonhampstead to Chagford, and, we believe, motor cars will soon be doing this journey. The L. & S.W.R. have recently started a service of motor cars from Exeter to Chagford, the distance being covered in some two hours.

#### NORTH OF ENGLAND COLLIERY SURGEONS AND THEIR FEES.

PRIOR to the formation of the Northumberland and Newcastle Medical Association, the colliery doctors in that county were paid by the miners 6d. a fortnight per family for medical attendance, which sum was supplemented by a small fee, varying in different localities, from grown-up sons and lodgers. This rule had continued for sixty years, but with the increased cost of education and of appliances it was felt by the medical men to be insufficient remuneration for a hard class of practice. Abuses, moreover, such as those of committee management, had begun to creep in. Four years ago the Association in question was formed and proved successful both in removing abuses and in raising fees to a minimum of 9d. per fortnight. Recently in several districts (especially in one where the miners had tried to fight this Association by means of imported practitioners) an agitation has been fomented amongst the men, but its leaders not finding their local efforts satisfactory, their delegates referred the matter to the County Miners' Union. At the request of the Union, representatives from the Medical Association met a committee of the Union and discussed the matter. The subjoined relates to the report made by the doctors' committee to this Association and adopted by them.

The difficulty which has for some time been cropping up amongst the miners with regard to medical fees has now entered upon a new phase in Northumberland. A statement has been issued setting forth the particulars of a conference on the subject between Messrs. H. Boyle, R. Young, G. Middleton, A. McKay and S. Morton on behalf of the miners, and Mr. Rutherford Morison and Drs. Cromie, Ruddock, and Bunting on behalf of the Medical Union, in which it is pointed out that since the doctors' fees had been raised wages had fallen 40 per cent. of the percentage above the miners' standard wage, and on this account the medical fees, it was contended, should be reduced.

The medical representatives claimed that the increased fee had not been asked for or granted because the miners' wages were temporarily high. The reasons were—

1. That for sixty years the medical fees for attending upon miners had been sixpence a fortnight. During this time wages in all occupations except medical had largely increased.
2. That sixty years ago a medical degree could be obtained with less than three years of study. Now the least time possible was five years. The time occupied and the expense of obtaining a qualification to practise were double.
3. That four years ago it was made illegal for medical men to employ unqualified assistants; consequently, all assistants must now be qualified, and it was difficult

to get them into colliery practice and expensive to keep them there. The attendance, now given being entirely by qualified men, is of more value than that formerly given; and

4. That the increased cost of drugs, instruments, dressings, &c., added materially to the expense of practice.

The miners meet this by asserting that many of the serious cases are now sent to hospitals, and that it is unusual to perform operations at the houses of patients.

On behalf of the doctors it is held that the advance of medical science has made hospital treatment necessary, and as an example an affliction common and serious amongst miners is given. For the cure of this 295 operations were performed at the Royal Infirmary, Newcastle, in 1903, and in 95 cases out of a hundred the cure is permanent, whilst so lately as ten years ago the operation was seldom performed with hope of success. For these cases no fees are received.

Against this the miners point out that in most colliery districts qualified nurses maintained by the workmen greatly assist the medical practitioners.

The medical representatives, after careful consideration, advise the Medical Association in the following terms:—"That in their opinion it is impossible to obtain and retain the services of qualified medical men of ability and good character for colliery districts at less than the fee of 9d. a fortnight, which was fixed upon as a minimum; that a reduction of the present medical fees would tend to lowering of the standard of medical work, and defeat the endeavour of our Association to increase the usefulness and the skill of our members."

The foregoing having been placed before the Council, the Miners' Association has been empowered to take steps to bring about a reduction of 50 per cent. in the fees now paid, the figures in the proxy vote being as follows:—For, 141; against, 30; majority in favour, 111.

It will be seen that the Miners' Association has been instructed to take steps to have the doctors' remuneration lowered by 50 per cent.

It therefore becomes a matter of imperative importance that medical men should refrain from taking appointments of any description in the county of Northumberland without first inquiring from Mr. Garforth Drury, of 95 Pilgrim Street, Newcastle-upon-Tyne, Secretary N. and N.M.A., or from Dr. Cox, Gateshead, Hon. Secretary North of England Branch, B.M.A.

#### CENTRAL MIDWIVES' BOARD.

MEETING HELD JUNE 30TH, 1904.

DR. F. H. CHAMPNEYS in the Chair.

DR. WARD COUSINS moved that "registered members of the medical profession only be eligible for appointment as examiners under the Central Midwives' Board." It was, in his opinion, eminently necessary that as the teachers were fully qualified as medical men the examiners should be so too, as only such could understand questions bearing on midwifery, and their medical *compagnons* felt very strongly on this point. Take, for instance, the duties of a midwife before and after labour; her duties with regard to sanitation, the feeding of infants, all such are safest to be taught by a medical man.

MR. E. PARKER YOUNG considered it retrogressive not to have fully qualified medical men as examiners.

MISS WILSON objected, considering a woman who taught nursing would be the best to put questions on that subject, and a fully qualified matron was capable of doing this. At any rate, the matter should be left in the hands of the Board. To this

DR. CULLINGWORTH agreed, arguing it might be taken for granted that no unsuitable person would be appointed. Undoubtedly women were fit for their own part of the work, but no strict rule should be laid down as to their appointment.

DR. SINCLAIR considered the matter ought to be finally settled, his remark being seconded by

DR. J. W. COUSINS, who considered nursing as a very high art indeed, and the duties of a lying-in room should be done by the best nurses. How could any woman, merely taught under the flimsy rules of a board of guardians, do this well? She might acquire a vast amount of book learning, but hospital or infirmary practice was absolutely necessary.

THE CHAIRMAN suggested substituting "may" for "must." In certain circumstances a highly trained midwife might be useful on the Board. There were many things a midwife could do better than the doctor, such as making beds and dressing babies, but he had to see that she did them.

DR. J. W. COUSINS here inquired whether medical men were to be asked to collaborate with unqualified persons.

IT WAS finally resolved that the Examining Board should consist of qualified medical practitioners only, the meeting then passing on to consider whether such should be obtained by advertisement or invitation, it being agreed and passed that invitation would produce better applicants. The question of payment was raised by

MR. PARKER YOUNG, who thought that if they were to have one examiner for every twelve candidates (oral) it would mean that he would work only three hours a day, and if not less than two examiners were appointed with a fee of 10s. 6d. for every candidate, where would the working expenses come from, the entrance fee being one guinea? It was finally agreed to reduce the payment to 7s. for each examiner.

MISS PAGET, at this stage, put in a protest against the arrangements for examinations—*i.e.*, that twice yearly the same papers should be given in London and the provinces. She maintained that to wait six months after failure was too long for a woman who had her living to earn.

DR. SINCLAIR, in reply, said a good midwife would not fail. If she did, things ought not to be made too easy, it being finally arranged that the words "oftener if necessary" should be inserted after the words "twice a year in London and the provinces," and an examiner to attend at the various centres of examination even if the candidates numbered below twelve.

#### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 3rd, 1904.

#### TREATMENT OF SPRAINS.

THE treatment of sprains depends, says Dr. Morestin, on the period in which the surgeon sees the patient. It is not often that he is called in immediately after the accident; generally one or two days elapse, when the blood has had time to effuse into the synovial bursæ or to infiltrate the cellular tissue. At other times, the accident is several days if not weeks old, and in such cases one is no longer in presence of a sprain but of its complications.

At the outset, the pain must be relieved and infiltration prevented if possible. Later, it will be necessary to obtain the absorption of the effusion, and hinder complications. When, however, the lesion is already of a certain date, these latter have to be treated. Formerly, a large place was given to "blisters" in the treatment of sprains, but they have for a long time fallen into disuse, and rightly so. But cold or hot applications have, on the contrary, rendered good service. Immersion in hot or cold water constitutes, when possible, a simple remedy not to be ignored. Baudens strongly recommended in cases of ankle sprains, plunging the foot in cold water and keeping it there as long as was agreeable to the patient, followed by a compressive bandage. The ice bag or, on the contrary, a hot-water bottle or hot sand are

sometimes excellent resources in sprains of the knee or the hip-joint. However that may be, the real curative treatment consists in mechanical means, by which the tissues are compressed so as to provoke absorption of the blood, lymph, exudations, or consecutive infiltrations.

Of these means, the most ancient is compression. Before cotton-wool was employed, it was a painful and even dangerous method, but with the apparatus as known to-day compression gives very good results. Yet this treatment is insufficient, and can only be justified by the impossibility of having recourse to massage, or the elastic bandage applied in the interval of the baths or the *séances* of massage; thus the apparatus is a means not to be neglected. The elastic bandage is, in the opinion of Dr. Morestin, the most perfect means of obtaining absorption of the blood or any other effusion into the joint provided it is not drawn too tight. Massage is of very general application, although its good effects were long ignored by surgeons. The pressure should be gradual, centripetal, and painless. At the beginning it should be light and superficial, so as to accustom the painful region to the contact of the hands. Gentleness is the principal point in the operation. Massage is particularly successful in ankle sprain. When applied immediately after the accident it works like a miracle. After from ten to twenty minutes of intelligent massage, the patient recovers the use of the articulation. In the case of knee sprain, massage would be rather prejudicial. The elastic bandage should be preferred after the first two or three days of the accident. Massage, on the other hand, is the only beneficial treatment of sprain of the hip and the shoulder, especially if employed at the very first, otherwise, if several days have passed, an apparatus for continued traction to obviate stiffness of the joints should be applied. As to rendering the joints immovable, the day has passed since such useless and hurtful treatment has been employed.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 2nd, 1904.

At the Society for innere Medizin, Hr. Eulenburg showed

#### TWO CASES OF ACROMEGALY.

The first was that of a machinist who had an accident three years ago. The speaker had been applied to for an opinion as to the connection between the accident and the now existing disease. The patient was standing before the water-level indicator of a boiler when an explosion took place. In his fright he struck away the object he was standing on and fell among the coals. He had numerous injuries about the face, complained of headache, and had a staggering gait. After a few days he went to work again, but soon had to give it up altogether. After this the symptoms of acromegaly appeared. These were most pronounced about the head, the hands and feet, the trunk, and especially about the vertebral column. There was marked widening and thinning of the sella turcica, and above the sella a half-dark shadow that pointed to tumour of the hypophysis. There were no other characteristic symptoms of tumour, and the field of vision was normal.

The question was: Was the acromegaly a consequence of the accident? The Court of Arbitration had decided not. An objection to this finding had been raised, and the speaker had given his opinion that the possibility of a connection between the two could not be denied. In confirmation of this were the facts that

acromegaly among men was very rare indeed after forty, and that in a collection of fifty-five cases it only occurred after that age in three, and in each case in connection with an accident. It was also a question whether the shock or the injuries, or both combined, should be looked upon as the cause.

The second case was that of a man, *æt.* 25, who had been shot in the face with small shot about four years ago. Some of the shot corns could still be felt under the skin. Some months later the patient took part in some military exercises, and, later, hemianopsia was noted, and at the same time the acromegaly. There had been no change in the condition since then. In this patient also the head, hands, and feet were very much changed, especially on the right side. Röntgen illumination showed widening and thinning of the sella turcica, but there was no shadow above it as in the previous case, so that there was no sign of a tumour of the hypophysis. Here the intracranial symptoms were markedly developed, hemianopsia, phthisis, imperfect action of the rectus internus muscle, polydipsia, hyperidrosis, and scoliosis of the vertebral column.

The speaker finally showed the Röntgen image of a third case, that of a married lady, *æt.* 29, who had never menstruated. For a long time she had suffered from orbital migraine then amaurosis of the right optic appeared, and distinct imbecility. The signs of acromegaly appeared later. The picture showed widening and thinning of the sella turcica and a shadow above it the size of a walnut; here also there was probably a tumour of the hypophysis.

MURETIN.

Hr. Litten spoke on muretin, prepared by the firm of Bayer and Co., and recommended as a depoisoned antifebrin, the daily dose of which was 0.5 gramme in divided doses. It was stated to be a very powerful antipyretic, particularly useful in the pyrexia of phthisical patients. The drug was handed to him for experiment, and the results of these had not corresponded to the promises held out. As regarded its harmlessness he had seen moderate collapse in one case and outbursts of perspiration in every case, that lasted for hours and left the patients exhausted. These sweats were so constant and persistent that patients refused to continue taking the medicine.

At the Surgical Congress the

PRESENT STATE OF THE PERITYPHLITIS QUESTION was discussed by Hr. von Büngner. He would make the attempt to bring about some convergence of the present very divergent views of physicians. He could therefore only discuss certain points. The pathological anatomists had revised their views as to the relation of the vermiform appendix to the peritoneum, as it had been shown that suppuration might be set up by the processus. Its length varied with age and other normal conditions. As regards its walls, the submucosa was the most important part, which was very rich in follicles. In his opinion an acute inflammation preceded the chronic, and not *vice versa*. The inflammation was generally limited to the submucosa and the muscular layer was usually destroyed along with the former. When late attacks came on perforation readily took place in those spots where these layers had been destroyed, and the mucous and serous layers lay together. Whether pus was poured into the peritoneal cavity depended on whether adhesion had previously taken place. There were both an acute and a chronic perityphlitis. The chronic form was usefully treated by operation. The appendix was extirpated so that nothing of it was left behind. In cases of pyæmia, the metastatic collections must be traced

out. In paratyphlitis the lumbar region must be carefully examined. In perityphlitic abscess early operation was indicated. The processus should not be removed unnecessarily, only when it was lying free.

He also distinguished a perityphlitis and an epitiphlitis simplex. Here operation should not be performed in the acute stage, say the moderate surgeons; the radical ones would operate in all cases to remove the threatened danger. In most recent times the majority of surgeons had expressed themselves in favour of early operation, but it involved certain risks. Cases of simple perityphlitis generally ran their course in about five days, and by the second adhesions had formed, which must be broken up at an operation. This involved the danger of leading to general peritonitis. One must decide early whether these cases should be treated surgically or medically. If the decision was to treat them surgically the operation should be performed on the second day at the latest.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 3rd, 1904.

#### GENU VALGUM ADOLESCENTIUM.

At the Gesellschaft Aberle exhibited a patient with bilateral genu valgum which, according to the history, had not developed earlier than the ninth year. The Röntgen rays proved the bending to be in the lower part of the femur in both legs.

The proper treatment to be followed was osteotomy, in accordance with the rules laid down by MacEwen and Schede.

#### PATELLAR FRACTURE.

Büdinger had two patients to show on whom he had operated for fractured patella. In both cases he applied para- and pre-patellar stitches without stitching the patella itself. Early passive movement in from five to seven days was applied, with a rapid healing of the fractured parts.

Eiselsberg prefaced a discussion on this form of treating fractured patellæ. He was also of opinion that both active and passive movements should be commenced in the first week of the treatment. Much was said by the following speakers for and against the treatment which might be summed up as speculative.

#### FREEZING RÖNTGEN BURNS.

Riehl showed the society a young woman who had suffered severely from burns on the chest caused by the Röntgen rays, which he had treated successfully by freezing the skin with ether chloride spray.

At the same time he showed a man, æt. 65, on whom he had acted with the Röntgen rays for an idiopathic, hæmorrhagic, cutaneous sarcoma with perfect success, as the morbid condition has now quite disappeared.

Freund remarked that this therapy of freezing in Röntgen ray injuries is consistent with the application of the Röntgen rays in dermatitis. As to the effects in sarcoma he was sceptical, as some do well, while others are unaffected.

Spiegler said he had a peculiar result from the treatment with the Röntgen rays in the case of a lady, whose chin became dark blue in colour.

#### UROSEPSIS.

Kornfeld gave the members a *résumé* of the symptomatology of urosepsis, which, he said, varied from local irritation, like prostatic hypertrophy, stenosis, &c., to the general hæmatic changes in fever. These he divided into (1) Uric fever appearing in an acute, recurring, or chronic form; (2) gastric phenomena; (3) nervous changes such as tetany, migraine, pigmenta-

tion, and trophic disturbance; (4) general enfeeblement or cachexia.

Blum remarked that morbid changes in the male apparatus, like prostatic hypertrophy, produced tetanoid phenomena, known by Trousseau as Chvostek's symptom. He was inclined to believe that the urine was not alone the cause of these tetanoid attacks and thought the prostate was as much to blame as the removal of the thyroid was for myxœdema. Basedow confirmed this connection by producing genital atrophy, which resulted in myxœdema. The very fact of metastasis occurring in mumps points to a glandular connection with the genital apparatus, and knowing that the removal of these glands produce a lowered state of the vitality it is reasonable to believe that the suspension or abolition of the prostate interferes with the poietic function of the organism by withholding some necessary secretion for perfecting the vital force. Another strong argument in favour of the genital origin of many of these diseases is the result of removing the ovaries which we recognise as ovarian cachexia. Is it not probable that atrophy or injury of the prostate will produce a similar result?

Kornfeld could not agree with Blum although he admitted there was a good deal of analogy in his argument. In the ovarian cachexia referred to, a number of the phenomena were present that dissociated it from the prostate; and furthermore very many cases of prostatic parenchyma destruction are met with where no cachexia exists.

#### THYROID GLAND AND EPITHELIAL CELLS.

The discussion on this subject was resumed. Pineles read a paper some time ago attributing the changes in the gland to alterations in the epithelial cells.

Escherich disagreed with Pineles' theory of the insufficiency of the epithelial cells being the cause of the tetany. In children, where tetany is more common under one year of age, the connection is more likely to arise from improper feeding than insufficient epithelial cells in the thyroid.

Jonas put forward "Gastric dilatation tetany" in support of Pineles' theory. The dilatation, he contended, was not the cause of the tetany, but an accident in the course of the morbid changes, while the insufficiency of the epithelial corpuscles could not be said to be due to the dilatation.

Loebl thought [the tetany in gastro-intestinal diseases could not be called accidental, as gastro-enteritis when severe always produced the Chvostek-Erb and Trousseau phenomena. In addition to this Italian experimenters have removed the cœliac plexus and produced tetany with all the associated symptoms.

Redlich concurred with Pineles in the belief that injury to the epithelial cells of the gland was the cause of the tetany. It is unfortunate for this argument that no exact proof can be brought forward to substantiate either hypothesis, but from the weight of inference adduced the proximate cause seemed to preside in the epithelial cell.

Frankl-Hochwart did not agree with Pineles, and would only ask one question, which he thought most pertinent. Why is it that tetany is so seldom met with in the site of the thyroid gland if it be due to insufficient epithelial cells? To this Pineles answered that the question supported the theory of cell insufficiency.

In the cretin the gland itself was only affected, while the epithelial cells remained unaffected.

In answer to those who had compared children, he quite agreed that the symptoms resembled strumipriva.



but were not exactly the same. The experiments of Königstein on animals conclusively proved this: that as soon as the epithelium appeared the tetany disappeared. It is possible, however, that gastro-intestinal affections may have the effect of reducing or otherwise rendering the epithelial cells inefficient, which would consequently produce tetany as expected.

### EGYPT AS A HEALTH RESORT.

[BY OUR SPECIAL TRAVELLING CORRESPONDENT.]

WITH your kind permission, I shall venture to give you some idea of the climatology of certain parts of Egypt, and inasmuch as so many who, after taking a tour of a few weeks only in Egypt, go back to their native country and compile works containing the climatic phenomena of the country, bearing pompous titles, as "Egypt and the Egyptians," or "Pharo's Egypt," &c., I may, perhaps, be excused as an individual who has resided for some considerable time in Egypt, with a good knowledge of Arabic and Egyptian biology, if I presume to pen the following. In this I shall try to give an outline of the climate and other interesting points of Suez, Geb-el-Tor, Ismailia, Port Said, Alexandria, Cairo, Luxor, Assouan, and Wady Halfa, leaving my fellow-practitioners to draw inferences and to recommend one or the other place as to the suitability of the patients under their care.

Suez is a small port inhabited chiefly by European employes of the Suez Canal Company, as well as by the different coaling agents and their clerks and a very limited number of merchants, and the main branch of the Eastern Telegraph Company and staff, having their own building, club, cricket and football team, &c. The residents of Suez, excluding the Egyptians, are composed of Greeks, Maltese, English, Italians, and the remainder mostly Austrians of different sects.

Terre-Pleine is about five minutes run from Suez town, where there are the Suez Canal offices, Suez Canal workshops, and shipping and coaling agencies; it is kept very clean, with a pleasant avenue and a good view of the harbour and canal. The residents from the balconies of their houses (which are situated on the Canal border) can see the transit of the different ships homeward and outward bound; hotels also exist at Terre-Pleine, the oldest of which is the Hôtel Bachet. The climate of Suez and Terre-Pleine during the months of July, August, and September is almost unbearable, but the heat is dry and no diseases prevail, except some cases of sunstroke and purulent ophthalmia, which can be avoided. During the winter season the climate is temperate, dry, and bracing, and, I believe, most suitable for persons suffering from asthma, rheumatism, and phthisis; but in summer I would not recommend the place to any. There are several well-known practitioners, of whom Dr. Creswell, principal medical officer, Government Hospital; Dr. Attfield, Director Quarantine Office, and Dr. Gautier, principal medical officer to the French Hospital, may be named.

Geb-el-Tor is a quarantine station on the Red Sea, about 100 miles from Suez, the inhabitants of which are for the most part Copts, appertaining to the Greek Orthodox Church. A branch chapel of the Grand Cathedral of St. Catherine of Mount Sinai exists at Geb-el-Tor. There is no vegetation bar a garden belonging to the said church, which is cultivated by the monks for their own consumption; there are no hotels, very few houses, practically speaking no trade, and steamers only call at that port in time of the Mecca Pilgrimage to obtain their "libra pratique" for the Canal. During the rest of the year a Government steamer runs to and fro during certain dates to supply the quarantine camp and the employes with their necessaries. What I desire to point out in this station is, that a natural thermo-mineral spring exists, called Mammram Mousa, which means Moses' bathing-place, encircled by a low mud and stone wall of very old standing, with different names engraved on the wall by Arabs and Europeans who had called there—but certainly not as the Arabs

believe—from the time of Moses. The waters of the said spring were analysed by me, and they contain sulphur, sodium, calcium, lithium and traces of iron and iodine, and I believe them to be very valuable in gout, derangements of the liver and in syphilis. Kindly note that I am writing from experience, and not merely re-echoing other people's belief. I therefore recommend those suffering from the above complaints, who have tried the Continental waters without any obvious benefit, to try once again the thermo-mineral spring at Geb-el-Tor, during the Mecca Pilgrimage, as then the tourist will be able in one way or another to find through the quarantine staff some suitable accommodation. The climate in winter is dry, bracing, and temperate; in summer it is very warm, but almost always with a favourable breeze during the evening; it is the healthiest spot in Egypt.

Ismailia is the centre station between Suez and Port Said, with the Suez Canal head offices; it is very neatly kept, there are many gardens, and vegetation is in abundance, but it is very monotonous and unhealthy. Malaria and intermittent fever prevail. The climate in summer is very warm, and in winter very damp; there are several hotels and, but for the Canal Company's offices and the cleanliness of the town, nothing is worthy of note.

Port Said is one of the most important coaling stations in the world, with a great many English firms, shipping agencies, and residents, in fact, the British population form the Port Said aristocrats, and by including the British subjects the importance of the town trade might be said to be ruled by them. Next comes the Greek population, and the remainder is composed of French, Italians, Austrians, and Montenegrins. The climate in summer is warm and damp; in winter, very damp and foggy; the town is not very clean and there are no gardens. Port Said, broadly speaking, is unhealthy, every other person is subject to neurasthenia, every three out of ten to rheumatism and gout. But should any tourist intend visiting Egypt, I would advise him to visit Port Said; there are several very good hotels, of which the Eastern Exchange is the most attractive. The town is always in motion on account of the different steamers that coal there and the landing of their passengers. The cafés, casinos, hotels, bars, shops, and the pidgin-English made use of by the Egyptians is worth while seeing and hearing. Port Said has some competent practitioners, Dr. Cuffey and Dr. Grillet (English), and several of French nationality.

Alexandria is a well-known city, and several English steamship companies have a regular service to that port. It is a very pretty place, with a large number of British residents and a well-directed municipality, which tries to put into execution all the latest sanitary improvements. Alexandria possesses some very good hospitals, of which the Greek hospital is the leading one, not only from a sanitary point of view, but as regards treatment and nursing, and is under the able management of Dr. Valassopoulos. Then comes the Deaconess' Hospital (also called the Prussian Hospital), of which Dr. A. Morrison is a regular attendant and who is not only a very capable surgeon but possesses in a high degree that *savoir faire* which is decidedly attractive to his extensive connection. As far as the sanitary arrangements of the hospital itself are concerned, some urgent things are lacking, but this is entirely due to the management, and not to the surgeon. Then comes the French hospital under the able management of Dr. Legendre (French) and Dr. Massa (Italian), and very shortly an English hospital will be built, as the funds for its construction are daily flowing in. The life at Alexandria is gay, the town is full of cafés, bars and other places of amusement; there are some very good Turkish baths of which El Hammam el Masri, situated at Sikkhat el Warsha, bears the palm. Half an hour's distance from Alexandria is San Stefano, with its beautiful casino and sea baths, and where every tourist can enjoy his bath and breakfast at a very reasonable price. Alexandria possesses the St. Andrew's School, having at its head Mr. A. Buchanan, M.A. As for the

climate, Alexandria is very damp in winter, and unsuitable for people suffering from constitutional diseases; in summer it is warm. The town is well worth visiting, and should any tourist require medical advice he may unhesitatingly and with entire confidence place himself in the hands of Dr. A. Morison or Dr. Legrand. Influenza and hepatic disorders are the prevailing diseases. In my next I shall treat of Upper Egypt.

## The Operating Theatres.

### MIDDLESEX HOSPITAL.

**CHOLECYSTECTOMY.**—Mr. JOHN MURRAY operated on a woman, *æt.* 46, who had been admitted with the following history:—In 1898 she had had an attack of pain on the right side with swelling; this was followed by jaundice. In 1901 she had a similar attack. Four weeks before admission she complained of pain in the epigastric region, accompanied by vomiting and marked tenderness in the right hypochondrium; a distinct swelling could be felt, somewhat ovoid in shape, extending about three inches below the costal margin. This last attack was followed by jaundice. On admission, the patient still had pain in the right hypochondrium, some tenderness on palpation, and a distinct swelling could be felt in the region of the gall-bladder. There was no jaundice. The woman's general condition was good. Operation was decided upon. A five-inch incision was made splitting the fibres of the right rectus, and the abdomen opened. The gall-bladder was adherent to the structures around, and when the adhesions had been separated the gall-bladder was drawn up into the wound and incised after sterilised gauze had been packed all around so as to shut off the peritoneum. It was found to be very much thickened and to contain a number of calculi; these were removed with forceps and scoop. After the gall-bladder had been cleared out the cystic duct was examined, and was found to contain calculi. On attempting to reach these through the gall-bladder the wall of the latter split longitudinally, and as the communication between it and the duct was so small that it was impossible to remove the stones through the gall-bladder, Mr. Murray therefore decided to remove this organ. It was therefore freed from the under surface of the liver, and was then easily drawn out of the wound, and the calculi in the duct extracted by slitting up the gall-bladder a little further. The gall-bladder was then removed and the stump of the cystic duct stitched to the peritoneum. The wound was then sutured in layers and a small tube inserted into the dilated portion of the duct and another into the peritoneal cavity at the lower part of the wound, which was then dressed. On counting the stones there were found to be thirty-eight, most of them being of moderate size. Mr. Murray said that in this case the diagnosis was obvious. Three attacks of pain, each followed by jaundice, and the presence of swelling in the region of the gall-bladder in the last attack, all pointed unmistakably to the presence of gall-stones. It was decided to operate, he pointed out, first of all because there had already been three definite attacks, secondly, because the gall-bladder could be felt distinctly four weeks after the onset of the last attack, and lastly because the pain and tenderness had persisted. With reference to the operation, he said that he preferred the incision through the rectus itself, splitting the fibres, to an incision in the semi-lunar line, because the wound was more easily brought together subsequently and there was less danger of a ventral hernia. With regard to the removal of the gall-bladder, this, he said, was necessary owing to the splitting of the organ during the

attempts to extract the stones from the cystic duct; the ease with which it tore was owing to the fact that the wall was enormously thickened, the thickening being due to the presence of inflammatory infiltration; apart from this, removal was the easiest way of extracting the stones from the cystic duct. The thickened and infiltrated state of the gall-bladder rendered its removal advisable. In speaking of the treatment he had employed for the duct, he said it was the safest on account of the quantity of muco-pus in the gall-bladder; for the same reason the tube had been introduced into the peritoneal cavity.

The tubes were removed on the third day; at the end of a week some bile appeared on the dressings, and this continued for a fortnight and then ceased. The patient left for a convalescent home a month after the operation.

### FRENCH HOSPITAL AND DISPENSARY.

**OPERATION FOR APPENDICITIS—INTERESTING FAMILY HISTORY.**—Mr. CLAYTON GREENE operated on a woman, *æt.* 20, who had been admitted for appendicitis, with the following symptoms: Pain in right iliac fossa, vomiting, and constipation. On examination, definite resistance was found in the right iliac fossa. The temperature was 101° on admission, but came down in two days, after a treatment consisting in the administration of a drachm of magn. sulph. every half hour. At the operation, the appendix was found with its tip glued down by adhesions in the pelvis. The adhesions having been broken down, the appendix was brought to the surface and found to be very congested and covered with a network of vessels. It was rather thickened, but no concretion could be felt. On slitting open the appendix no concretion was found, but only a small quantity of viscid mucus. The appendix was removed by turning back a cuff of peritoneum, next passing a purse-string suture round the cuff, then removing the appendix, and turning in the free edge of the peritoneum so as to get the stump of the appendix inside the cuff, and, finally, drawing the purse-string suture tight. The wound was closed in three layers. The peculiarity about this case was that the whole family, *viz.*, the father, the mother, two brothers, and two sisters, and the uncle, all had suffered from appendicitis. The mother died without operation, the uncle and two sisters were operated on and recovered, and the two brothers recovered without operation.

The patient's temperature never rose after the operation, and in a week she was convalescent, the pain and tenderness having disappeared.

### 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 24th ult. There were present Dr. de Havilland Hall in the chair; D. J. Pickett, Dr. St. Clair B. Shadwell, Mr. J. Brindley James, Dr. M. Greenwood, Dr. Walter Smith, Dr. W. Knowsley Sibley, Dr. F. J. Allan, and Dr. J. B. Ball. The accounts presented showed that the business of the Society is satisfactorily growing. Each year a large addition has been made to the funds, which now amount to £180,000, and it is estimated that during the current year more than £10,000 will be paid to the members as sickness allowance. The list of those permanently incapacitated shows no sign of lessening although several deaths have occurred among them during the last four months, but fresh cases have come forward, and the number of those who have to draw annuities, generally one hundred guineas a year, steadily grows. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33 Chancery Lane, London, W.C.



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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 6, 1904.

**THE IMMUNISATION OF PERITONEAL WOUNDS.**

THE extreme sensitiveness of the peritoneum and its peculiar liability to septic infection are the chief factors with which the surgeon has to contend in any operation upon the abdomen and its contents. Wounds of this serous membrane so lower its resistance that it becomes a more easy prey to septic organisms, while the *bacterium coli* itself is well known to acquire, under certain conditions, pathogenic properties. Peritoneal infection from the mucous membrane of any part of the gastro-intestinal tract still occurs with too great frequency, in spite of the most elaborate precautions. We are here face to face with a grave problem, namely, the prevention of such infection and the consequent diminution in the mortality after operations upon the stomach and intestines. In certain diseases characterised by an invasion of the system by specific organisms, which at the same time secrete toxins, we have, to some extent, the power of producing an artificial immunity by the injection of a specially prepared serum, or antitoxin. Successful as many of these sera have been, there is an undoubted difficulty in adjusting or adapting them to the varying strains of the same organisms, the virulence of which is seldom constant. This is a disadvantage which will be gradually overcome by greater perfection in bacteriological technique, as well as by an increased knowledge of the life history of pathogenic germs. Many experiments have also been undertaken with a view to the preparation of prophylactic sera, a few of which have been put to practical use, as, for instance, in the inoculation against typhoid fever. The other method, and the only one which, in the present state of our knowledge, is applicable to infectious conditions of the peritoneum, is that

of increasing the power of resistance of the body against bacterial invasion. This aspect of immunisation is the one dealt with by Professor von Mikulicz, of Breslau, who delivered before the West London Medico-Chirurgical Society the Cavendish Lecture, published in our present issue. The production of a hyperleucocytosis is one of the means by which this increased resistance is attained, and the experiments of Loewy, Richter, Jakob and Hahn have shown that certain animals have been rendered immune against pneumococcal and septicæmic infection by the injection into their bodies of substances capable of exciting hyperleucocytosis. Intra-peritoneal injections of normal saline were employed in 1902 by Salieri for the purpose of increasing the resistance of the peritoneum against infection, while Issaëff had also experimented in the same direction. The possibility of thus immunising peritoneal wounds in the human subject has been made a special study by Professor von Mikulicz, after further experiments had been undertaken upon animals by all the different methods tried. A 2 per cent. solution of neutralised nucleic acid was found to be the most efficacious in producing hyperleucocytosis. This was injected in man subcutaneously, in quantities of 50 c.c., and in no case was any serious local or general manifestation observed. In all, fifty-eight cases were thus injected, fifty-five of which were operations upon abdominal viscera and three of extra-abdominal disease. The only sign of reaction was a slight rise of temperature during the first few hours after the injection. As far as results are concerned, the number of cases treated in this manner is admittedly small, but in forty-five laparotomies in which the peritoneum was exposed to infection from the contents of the stomach or intestines, seven only were fatal, and in none of these was post-operative peritonitis the cause of death. The operations were undertaken on the "rising tide of leucocytosis," which attains its maximum in man about ten or twelve hours after the preventive injection. Solutions of normal saline appear also to have the power of increasing the resistance of the peritoneum to *B. coli* infection, hence the practice adopted by many operating surgeons of irrigating the peritoneal cavity with this fluid after laparotomy would seem to be based upon scientific principles. This method of producing artificial immunity of the peritoneum should prove of great advantage to surgery in general, and, if confirmed by subsequent observers, will do much to rob operations upon the abdominal viscera of their dangers.

**PUBLIC HEALTH ADMINISTRATION.**

FOR many years business men have been anxious to see the Board of Trade re-modelled, and its Parliamentary chief raised to the dignity of a Secretary of State, whilst those interested in social matters have been advocating that a similar process of transformation should take place at the Local

Government Board. As the result of these agitations a Committee was appointed by the Treasury last year, charged with the duty of investigating the two proposals. Their report has just lately been issued, and it cannot be said that its recommendations will be very satisfying to those ardent spirits who wished to see a Minister of Public Health, with all the dignity of Cabinet rank, created to infuse vigour and initiative into the public health administration of the country. The Committee has taken a narrow view of the terms of reference supplied to it, and, with regard to the Local Government Board, has confined itself to the question of the salaries paid to the higher officials in making positive recommendations. These recommendations are in themselves a step in the right direction, for they propose that the President's salary shall be raised to £3,000 a year, and those of the Parliamentary and Permanent Secretaries to £1,500 and £2,000 respectively. On the accepted principle that people value a man's opinion in proportion to what they pay him for it, it may now be anticipated that the prestige of the Local Government Board will be somewhat increased if the Committee's recommendations are adopted, but that is all. On the negative side, however, it is to be noticed that the Committee had before it two suggestions, both of which it rejected. One was put forward by the British Medical Association, and embodied the views of the Council that the President of the Board should be a Secretary of State, with full emoluments and status; that one of the members of the Board should be a medical man, and that the administration of the Medical Acts should be transferred to the Board from the Privy Council. The other was that of the Public Health Committee of the House of Commons, presented by Sir Michael Foster, advocating that the health duties of the Board should be divorced from those relating to the Poor-law, and taken over by a separate staff acting under a Parliamentary secretary. The Committee thought, with regard to the proposal of the British Medical Association, that the duties of the Board were already sufficiently onerous, and that it would be a mistake to increase them, whilst it held that to adopt Sir Michael Foster's proposals would be attended with considerable practical difficulty. It may, therefore, be taken as settled that any change in the constitution or organisation of the Local Government Board is out of the question for the next few decades, and the public health administration of this country will continue to proceed on its old lines for good or for evil. It is a great pity that this opportunity for reform has been lost. The growth of the Local Government Board's work since its institution in 1871 has been prodigious, and it is now the largest of the Government departments. Every day almost sees an increase in the business it has to transact. Interest in matters relating to local government has grown more and more as people have realised that their interests lie in their own hands, and that if they suffered from disabilities and grievances,

it is due to their own inertia in not removing them by constitutional means. But with the healthy devolution of powers it has been found necessary to keep a firm control over irresponsible and extravagant boards by the central organisation, and, on the whole, it must be admitted that the influence of the Local Government Board has generally been for good. Still, the complex and multifarious duties of the Board are such that administrative jumbles cannot be avoided, and when the importance of safeguarding the public health in our present crowded towns and cities is considered, it is of the greatest moment that a strong, well-staffed and vigorous Board should be available to co-ordinate and control the policy of the various authorities carrying out the Acts in the districts they serve. The association of the poor-law with public health is not a happy one, for, however much one may wish the former to be construed humanely and intelligently, it has not the vital effect on the very existence of the community that the Public Health Acts have, and, like poor relations, it tends to bring obloquy on its associates. Drains and water-works do not fire the public imagination, and when they are joined with workhouses and casual wards, they tend to be looked upon as unfortunate necessities—that are best left to other people. The situation may be summed up by saying that the whole of the public health administration suffers from lack of dignity, and that while the Local Government Board continues to be a minor office, as a reward for a good party hack, in which he may serve his apprenticeship to the higher grades in the Cabinet, so long will the public health service continue to be regarded as of secondary importance to the State. Any hope of seeing it otherwise is postponed indefinitely by the Committee's recommendation.

#### HOSPITAL ABUSE.

WE have for several years past, whenever the opportunity offered, impressed on our readers the magnitude of the evil involved in the present system of hospital administration, and we have done our best to suggest the lines along which reform should take place. At present, there is little doubt that the class for whom hospitals have been founded and are maintained—the necessitous poor—is not the class who make most use of them. On the contrary, the wards are occupied and the dispensaries crowded by well-to-do artisans and people of the lower middle class, who ought to be, and are, able to pay for medical attendance. A double injustice is thus done: the money contributed by the charitable public is to a large extent misapplied, and at the same time the general practitioner is deprived of his legitimate means of livelihood. In addition, and perhaps of even greater importance from a sociological point of view, is the concomitant pauperisation of a large class of the community. The persons responsible for the present state of things are primarily the governors of hospitals, for it is to them that the administration of the hospital

funds has been entrusted by the charitable public. The responsibility, however, does not end with them, for it is the duty, in this, as in other matters of hospital management, of the medical profession in general and of hospital physicians and surgeons in particular, to keep the boards of governors in touch with the best opinion. In a previous discussion (a) of this subject, we laid down what we thought should be the guiding principles of hospital boards in the matter—"efficiently to relieve the greatest amount of suffering with the maximum amount of economy that efficiency will permit, and to see that funds collected in the name of charity are expended in the furtherance of charity." To aid in the carrying out of these principles, we suggested that inquiries should always be made as to the means and circumstances of patients attended at hospitals, and that, if necessary, a special officer should be appointed whose duty it would be to make such inquiries, and verify them by further investigations if thought advisable. Although but little attempt has yet been made either by hospital boards or by the profession to inaugurate any serious reform, it is something that the profession is at length being roused to take an interest in the matter, and as a sign of this we welcome the action of the Dublin Division of the British Medical Association in requesting its Executive Committee to inquire into the alleged abuse of Dublin hospitals and their dispensaries. The special report drawn up is being considered at the annual meeting this week, and deserves very serious consideration. The Committee state what, indeed, is notorious, that patients who are able to pay for treatment outside are at present in receipt of hospital relief and treatment, and they are of opinion that the only practical way to meet this abuse is to compel such persons to pay for the treatment received. While we are in the main in agreement with these expressions of opinion, and believe that the only way to exclude undeserving patients from hospital relief is to charge them a fee commensurate with what they would pay for similar advice elsewhere, we fear that some of the suggestions made by the Committee are liable to be misunderstood. As long as the charging of fees for hospital treatment is used simply as an instrument of protection from imposture, it is both admirable and effective, but if it is to be used to any degree as a means of income, for either the hospital or its medical staff, it is liable to very serious abuse. A card which the Dublin Committee suggest for use by the governors of Dublin hospitals in recommending patients for treatment, in its present form, at any rate, would leave the way open for some misuse. It consists of two alternative forms of recommendation; one, in the case of needy patients unable to contribute anything, and the other recommending so-and-so "as a pay patient, unable to pay more than £— per week for treatment." It seems to us that the latter

clause may act in quite the contrary way to the intention of those who framed it, and might simply result in turning the general hospital into a gigantic general practice, which, aided by its prestige, influence, and funds, could compete with neighbouring practitioners at cut-rates with disastrous results. As we know nothing could be further from the intentions of the Dublin Division than such a result of their action, we venture to draw attention to this matter of detail, while fully concurring with the general views of the Committee as to the desirability of testing the means of all applicants for charitable medical relief.

## Notes on Current Topics.

### Criminal Charges and Insanity.

BRITISH law is a complicated engine that creaks ominously as it wins along its slow and laborious journey. Criminal law is at present administered by the police, whose one desire appears to be to shut up as many persons for as many years as magistrates and judges will permit. As a rule, unsupported evidence from a police constable is practically law, a fact which helps him not a little in attaining the highest possible position in the force, namely, that of a constable who has never failed in a prosecution. The scientific treatment of criminology is unknown in our law administration. An accused person may be palpably mad as mad can be, but nevertheless be committed to gaol for short or long terms of punishment. The need of some advisory board of lunacy experts was shown last week at the Old Bailey. A woman, formerly a prisoner at Lewes Gaol, on her release from that place brought an action for breach of promise against a major-general of the neighbourhood, one of the visiting justices. The action was fantastic, grotesque, and erratic, and naturally failed. Subsequently the plaintiff was prosecuted for perjury, and in a first trial the jury could not arrive at a verdict. In the second trial she was found guilty and sentenced to four years' penal servitude. With the propriety of that sentence we are not here concerned, beyond pointing out that the first jury clearly thought there was room for doubt. The point to which we would call attention is that the state of the prisoner's mind was not scientifically determined. The Common Serjeant, who tried the second case, asked if there was any reason to suppose the woman was wrong in her head. Then up and spake a bold detective-inspector, "Oh, no! my lord. She is a very wicked, dangerous and clever and designing woman." That illustrates the average attitude both of the police and of the lawyers with regard to mental responsibility of alleged criminals. It seems incredible that the Common Serjeant of London should be content to take evidence as to mental soundness from a policeman. But there is a glimmer of hope, for we no longer hang for petty thefts, and have we not the Bertillon methods of detection, and a First and a Juvenile Offenders Act?

(a) MEDICAL PRESS AND CIRCULAR, August 28th. 1901.

### The Post Office as Censor.

WE have often complained of the inertia shown by the Post Office authorities both here and in America in regard to the nature of the advertisements which pass through the mails. Although it is in print as a rule of the Office that no indecent printed matter shall be allowed to pass, it is notorious that we are pestered day by day by advertisements of various proprietary medicines which are offensively indecent, not only in printed matter but in accompanying illustrations. In the lower class of our own newspapers, also, and in many American journals, advertisements inciting not merely to immorality, but to actual crime constantly appear, and the papers have a wide distribution through the post. Under the circumstances, it is good news to hear that the United States Postal Department have at length determined to institute an effective censorship against the passage through its channels of offensive advertisements. The regulation is to apply, not merely to indecent advertisements, but to announcements of patent medicines and other quack remedies wherever chemical analysis reveals premeditated fraud. It will be enforced also against newspapers, which, after warning from the Post Office, continue to admit quack advertisements to their columns. In all such cases, the papers will be excluded from the mails. The energies of the American postal officials will be fully occupied for some time to come in deciding, as they promise to, "every case on its merits." As a consequence, moreover, their exchequer and our waste-paper baskets will be somewhat the lighter.

### Gas Stoves.

IN and around London the old-fashioned home is gradually tending to disappear. The working-classes, aping their (so-called) "betters," are deserting houses and cottages for flats and those euphoni-ously-named substitutes for all that is desirable, "maisonettes." The artisan and the labourer no longer settle down to the enjoyment of love in a cottage, but wander about and migrate from one quarter of the city to another. Their houses are no longer their castles, but mere shifting tabernacles, and their aim is to limit as far as may be the expenditure of time, thought or money upon the environment of the dwelling to what is absolutely necessary. Anything, therefore, that saves trouble is welcome, and the gas-stove, rented from the company, undoubtedly economises the energies erstwhile devoted to cooking with the old-fashioned kitchen range. A penny-in-the-slot provides a supply of gas, and there is an end of the matter; the old bother of making up a fire or of cleaning the grate has vanished. But the ease thus obtained is dearly purchased, for these gas-stoves are provided with no adequate shafts to conduct their fumes into the external atmosphere, and, consequently, the products of combustion are retained in the kitchen, or find their way by diffusion into the bedrooms. A more unhealthy

contrivance could scarcely be imagined. The carbonic acid, sulphurous acid, and other products of combustion, accompanied by the fumes of volatile fats and particles of organic material from the food that has been cooked, contaminate the air of the building, and are breathed and re-breathed by the whole family. Nor are the working classes the only sufferers in this respect. The same reasons that lead them to use gas for cooking influence those of the upper classes who live in flats and small houses; and although—from the greater air-space available—the family are not so much affected, the servants who pass their time in the kitchen are poisoned daily. No gas-cooking apparatus should be allowed to be used, unless provided with a thoroughly efficient extract shaft for the products of combustion. Let him who doubts these things look at the walls and the ceiling of a room where a gas-stove is in frequent use.

### Lilies versus Roses.

UNTIL comparatively recent years one used to expect a certain amount of good sense in newspapers during the major portion of the year, relieved by nonsense only during the few weeks in the heat of the summer, when "copy" was scarce and the regular writers either slack or holiday-making. But with the phenomenal growth of journalism during the last twenty years or so, it has been found impossible to maintain a high standard of accuracy and interest—at any rate in the less responsible journals—and nowadays nothing seems too silly to "fill up" the columns of some of our contemporaries. A paragraph is going the rounds of the ladies' papers, by far the worst offenders, that a "foreign chemist" has made the brilliant discovery that the lily of the valley has a depressing effect on the heart, so that a spray worn by a lady on her bosom will make her appear cold and listless, though were roses lying there she could be responsive enough. The only hearts that are likely to be depressed are those of the medical men who read such stuff as this. The lily of the valley is one of the oldest medicinal plants known, and though it had almost become obsolete at one time, it has recently been growing in favour, as its active principle, convallaria, has an action remarkably like digitalis, and when that drug acts unfavourably, convallaria is often used as a substitute. Although a rather active poison, convallaria in small doses is a cardiac tonic, and if the odour of the lily of the valley could exert any therapeutic influence—which is inconceivable—it ought to be a stimulating one, whilst the rose is medicinally one of the most inert of plants. One can assure the ladies, therefore, that if they wish to add to their charms by wearing the most modest of flowers, they may do so without fear of ulterior consequences, and that the lily of the valley is, if anything, more likely to stimulate their hearts than the rose of Sharon. Possibly, after all, the writers of this amusing fiction had in their minds former experiences of joy or sorrow

produced in their own masculine bosoms by the sight of roses or of lilies worn by lovely woman.

#### Removal of the Gasserian Ganglion.

THERE are few accepted operations in the range of surgery which appear at first sight more difficult of accomplishment than the removal of the Gasserian ganglion, and it is not to be wondered at that few except the most courageous surgeons have so far been found to practise it. Yet there is no operation which is more urgently demanded in certain conditions than this, since in cases of persistent and so-called "intractable" trigeminal neuralgia it stands out almost the only treatment which may substitute a life of ordinary comfort for one of intolerable misery. At the same time, the operation is not by any means so hazardous as is generally supposed. The mortality during the past two or three years has been rapidly lessening, and in the hands of Sir Victor Horsley, who has operated on as many as 120 cases, has run as low as 2½ per cent. The higher rates of mortality in the practice of other surgeons are due, not so much to any want of skill in the actual performance of the operation as to a reluctance to undertake it before the patient has become exhausted by continued pain, loss of rest and food, and often by narcotic drugs. Surgeons who, following Horsley's example, have had the decision to operate early, have not, as a rule, had any difficulty in obtaining results as good as his. It should be remembered, however, that the operation is one of the most serious that can be performed, and it should never be undertaken by a surgeon who is not thoroughly conversant with the anatomy of the floor of the cranium and the parts adjacent thereto.

#### Efficiency of Surgical Dressings.

It is curious how little fixity of knowledge there is as to the relative advantages of the various materials used in surgical dressing. Each surgeon has, as a rule, his favourite materials, which he uses with but little variation, though from time to time he drops one or other from his store, and substitutes something new. He, indeed, usually places implicit confidence for all purposes in the substance he is using at the moment, though it captivates his good opinion but for a short time. He is, however, rarely ready to offer any scientific grounds for his use of a particular material. He finds it work well, and he is doubtless right to hold by it, but it would be more useful to himself and others to make some inquiries as to the points in which it is successful, and the points where it fails. It is to satisfy themselves in a scientific way as to the efficiency as drainage materials of various popular surgical dressings that Drs. M'Gregor and Ramsey, of Glasgow, have performed a series of experiments recently communicated to a contemporary. (a) Working with absorbent wool, wood-wool, cellulose, boracic lint, and various gauzes, they tested the powers each material shows in absorbing and in

conducting moisture. It is to be noted that the two properties are not at all identical, for some of the materials which were able to suck up moisture with ease were but badly able to transmit it. Again, some materials, while acting as excellent drains of fluid, were quite unable to convey cellular elements. Speaking generally, the observers come to the conclusion that for the transmission of fluids with solids in suspension, dry boracic lint forms the most efficient drain. Cellulose wadding is nearly as useful, but its friability renders it difficult of application, unless enclosed in gauze. As a simple mop or sponge to apply to an open wound, absorbent wool and cellulose are found to be equally trustworthy. It is important to note that even the best drain gets blocked in less than eight hours, so that a more frequent dressing than is customary is indicated.

#### Foot Massage.

It is refreshing to hear of a really sensible American craze, especially when the goodness thereof threatens to invade our shores. The report comes that we are to be inundated with a wave of "foot massage," a form of chiropody that aims at restoring the function of the toes so that they may be able to perform the movements that Nature designed them to execute. But it is not so much the foot massage itself that deserves commendation as its corollary, namely, that pointed toes and tight boots will go out of fashion. If the toes are to be made capable of flexion and extension at will, it is obvious that the massage will be of little avail if, in the interval between the treatment, the toes are to be encased in boots which pinch and restrict them. It will be necessary for the art of the masseur to be backed up by the common sense of the subject, and if this entails the wearing of well-fitting boots and shoes, not only will the practitioner be relieved of many of his difficulties in treating bunions and ingrowing toe-nails, but many ladies will sigh with relief to think that they can enjoy a comfort in walking that fashion has denied them for so many years. Let the foot masseur come and do his best; if he succeeds where doctors and their warnings have failed, they will not grudge him his success.

#### The Dual Aspect of Medical Practice.

THE calling of medicine is one which may be viewed from many different standpoints. The most lofty is perhaps that which regards the physician as the true exponent of the healing art, equipped with special knowledge, and endowed with powers wherewith to combat disease in every shape and form. The practitioner thus stands before all men on a higher plane, ever ready to give, and to give freely, to all and sundry who apply to him for relief from their sufferings. This is the humanitarian view which supposes that the doctor is actuated by no other motive at any time than that of pure philanthropy. We are proud to believe that many from among our ranks have, indeed, served their day and generation without

(a) *Brit. Med. Journ.*, June 11th, 1904.

ever a thought of reward, and out of pure love to their fellow-creatures. Would that it were possible for every member of the profession so to practise, but, unfortunately, such an ideal is out of the question, save for a privileged few. The commercial aspect of medicine forces itself upon the attention of the majority of its practitioners, producing a jarring note upon the ears of many, but to others, unwillingly perhaps, in the first instance, it offers the only possible solution to a life which could scarcely exist at all were the highest ideals to be slavishly followed. Regarded from this point of view the medical man or woman is only a skilled workman whose services have a definite money value in the world's market. The doctor must live as well as his patient, though the latter often fails to recognise the fact. Public bodies, and even the State itself, also ignore it, with the result that a great outcry is made whenever a medical practitioner ventures to assert his rights and demands payment for his services. Too much gratuitous work is demoralising to the public, and must slowly tend to the destruction of the physician's humanitarian instincts. Every labourer, even those in the field of medicine, is worthy of his hire.

#### Two Sides of the Body.

THE belief in the inferiority of the left side of the human body is one of those popular superstitions which have been handed down from remote ages, and which is shared, to some extent, by the members of a learned profession even at the present day. It is well known, for instance, that pain is more frequently felt upon the left side, and it is quite a common saying among gynaecologists that the sinister half of the body is the weaker and less resistant. Sometimes there is an anatomical explanation for this, as, for example, the presence of a loaded sigmoid flexure. The mode in which the spermatic veins empty themselves may account, in some degree, for the greater prevalence of varicocele upon the left side. The evolutionary factor which has resulted in the superiority of the left cerebral cortex has had, of course, the chief influence in enduing the right side with greater powers than the left. As far as we are aware, no observations have been made as to whether left-handed individuals suffer pain more acutely upon the left side of their bodies, but there is no reason why the sensory as well as the motor conditions should not be reversed in such. Tradition and sentiment have, probably, much to do with this ancient belief. Not only is the left side supposed to be inferior in function to the right, but it has been credited with being of sinister import. The common saying that the individual whose left ear tingles is being spoken evil of would appear to have its origin in great antiquity. Dr. Richard Caton, in the course of the Harveian Oration before the Royal College of Physicians, referred to a passage from an ancient Egyptian papyrus, in which it was stated that the "breath of life" was contained in the right ear, and the "breath of death" in the left. This is,

in all probability, one of the earliest references regarding the common belief in the sinister import of the left side of the body.

#### The Need of a Standard of Purity of Food and Drink.

AT no time up to the present has there been so much activity shown by local authorities in enforcing as far as is legal a high standard of purity of articles sold as food. The administration of the various Acts is, as is well known, in the hands of local bodies, who are, however, as in the case of other matters of public health, under the supervision of the Local Government Board. In a question of public health, however, a local board acts under the direct advice of its medical officer, who is himself in close relation with the medical department of the Local Government Board, which thus establishes a certain uniformity of policy throughout the whole country. As regards food and drink, however, there is no such uniformity of standard of policy. The examination of specimens is in the hands of an analyst, whose duty is limited to reporting on specimens submitted to him. He has no advisory functions, and he is not brought into contact with the Local Government Board, whose control is, under present conditions, entirely nominal. Dr. Louis Parkes, who draws attention (a) to the present unsatisfactory state of affairs, suggests that the Local Government Board should provide themselves with expert advice from a person not only skilled in methods of analysis, but having expert knowledge of the various manufacturing processes employed in the preparation of food and drink. Aided by a staff of trained inspectors, it should be his duty to exercise general supervision, not only over the sale of articles of food, but over their manufacture or importation. He should further lay down standards for the purpose of sale of foods and drugs, and the Local Government Board could thus impose uniform standards on the various local authorities.

#### Latter-Day Recruiting.

THE returns of recruiting given in the lately issued Report of the Army Medical Department for 1902 are of an interesting nature, some incidental light being thrown upon the question of the alleged physical degeneracy of the nation. During the year, out of 87,609 recruits inspected, no less than 26,913, or 30.719 per 1,000, were rejected as unfit. The chief causes of rejection were as follow:—

Defective vision .....	3,437
Disease of heart .....	1,518
Disease of veins .....	1,078
Loss or decay of teeth .....	4,316
Defects of lower extremities .....	1,075
Flat feet .....	1,090
Malformation of chest and spine ..	395
Under height .....	1,015
Under chest measurement .....	4,969
Under weight .....	1,903

The total number of rejections was increased on

(a) *Practitioner*, June, 1904.

that of 1901 by nearly a third, probably in deference to the abandonment of Mr. Brodrick's Army Corps. It is interesting to note that one of the chief causes of rejection was non-existent as a medical test a few years ago, namely, defective teeth.

#### The North of England Miners' Dispute.

THE North of England colliery doctors, as recorded elsewhere in our columns (page 11), have recently formed themselves into a strong and united body under the name of the Northumberland and Newcastle Medical Association. They succeeded in raising fees from the inadequate scale that had been in force for the last sixty years. The miners, however, have resolved to cut down medical remuneration by something like 50 per cent. The matter has now entered the fighting phase. Quite recently the miners have imported medical men, hoping therewith to reduce the established colliery surgeons to terms. It is to be hoped that no medical men will be found willing in the present dispute to accept any such degrading position. Treachery of that kind, unfortunately, is not punishable as "infamous" conduct, but it is certainly regarded with universal detestation and abhorrence by all honourable members of the medical profession.

#### Vaginal Secretions.

THE mystery that attaches to not a few cases of infection of the female genitalia makes of value every contribution to our knowledge of the functions and constitution of the secretions of the various portions of the genital canal. An interesting paper, (a) discussing the question of the possibility of auto-infection in the puerperium, has lately appeared from the pen of Wladimiroff, of the Pasteur Institute. It is now generally agreed the normal vaginal secretion is actively antiseptic in virtue of the lactic acid produced in it by the vagina-bacillus, and as this bacillus is normally present, any stray organisms that may enter the vulva by means of instruments, pessaries, and such agencies generally perish, unless introduced in overwhelming force. The cervical secretion, on the other hand, is sterile, and neutral or alkaline in reaction, so that it forms an admirable culture medium for bacterial growth and activity. Although the vaginal secretion is generally increased as to acidity during pregnancy, during the puerperium all acidity disappears for five or six weeks, and thus it has seemed that the lochial secretions would tend to furnish a ready field for microbic invasion. The wonder would therefore average sojourn being close on four months. Excluding seven cases which were only under treatment for a month, the disease was arrested in twenty-four, and improved in twenty. At present the finances compel the directors to fix the charges at a minimum of £1 per week; but to benefit the working classes, considering that a residence of six months is desirable, they ought to be able to admit at from 5s. to 10s. weekly. This would do much to enhance the usefulness of the institution by inducing cases to come early enough and to stay long enough to have a good chance of being

during the puerperium tend to inhibit and finally destroy pathogenic organisms by phagocytosis, but that bacteria existing in the passages before parturition can gain a foothold in the tissues only if those passages are injured during labour. This explanation, if the right one, will help to clear up a good deal of obscurity.

#### Vermin in Children's Heads.

A NOTE on this subject which appeared in these columns a few weeks ago attracted a good deal of interest among those who have the credit and health of the rising generation at heart. It was pointed out at that time that the present moment afforded an especially favourable opportunity for the new educational authorities to take steps to end the disgrace of having most of the children attending elementary schools infected with head-lice. The Brighton municipal authorities, advised by their able and energetic medical officer, Dr. Newsholme, are never slow in acting up to the level of the best opinion of the day, and one notices with satisfaction that they have taken this matter seriously in hand by appointing a trained nurse in the place of an attendance officer. By this means an instructed and experienced person will be able to visit the children's homes and bring their condition as to cleanliness to the notice of the parents. Although there will be no legal compulsion to make them conform to the advice given, it may safely be assumed that a tactful presentation of the state of things will be pretty generally successful in making the parents ashamed of their delinquencies. The nurse is to act directly under the medical officer, and will assist also in visiting houses when infectious disease has broken out, so that her functions will be manifold. It is to be hoped that Brighton's example will encourage other authorities to go and do likewise.

#### Aids to Dissection.

IT will be generally admitted that a thorough grounding in practical dissection is indispensable for all those who seek to obtain a working knowledge of the way in which the human body is built up. To the surgeon especially an intimate acquaintance with the minute details of anatomy is essential, and hardly less so to the physician. Yet, strangely enough, this is the very part of the medical student's studies most often shirked, the more so in these days of diagrams and photographic illustrations. Dissecting is sometimes irksome, but time spent in laboriously hunting out a minute vessel or in tracing a course of an almost invisible nerve is well spent, for there is nothing like actual use of the knife and forceps to impress anatomical details indelibly upon the memory. Half an hour spent in the dissecting room of a hospital is better than three hours passed, book in hand, in a wax-model museum. However faithfully a part or organ of the body is modelled, the natural colours included, and however realistic



photographic representations of the same may be, they cannot take the place of manual dissection. We notice that a new stereoscopic atlas of human anatomy has recently been published, and while we marvel at the vividness of "parts" portrayed in this fashion, and have nothing but admiration for the excellence of the illustrations, we feel that a word of caution is necessary lest the student should be tempted to trust to these and similar means of acquiring anatomical knowledge instead of going straight to the dead body itself. In their right place such atlases and diagrams may be true "aids" to dissection, but there is a danger lest they should become hindrances by being substituted for individual manual labour in the dissecting room. *Verbum sap.*

#### Disinfection of the Clinical Thermometer.

THE little instrument of precision which is carried about by every medical practitioner, and which alone is the correct guide to the state of the patient's temperature, has often been anathematised by its users. At one time the index cannot be shaken down, while at another it is too fragile or the reading is said to be inaccurate. These supposed faults are, in many instances, due to the manner in which the clinical thermometer is used rather than to the instrument itself. Another charge, however, has a sounder basis, namely, that it is often the medium by which infection is conveyed from one person to another. Like any other apparatus brought into intimate contact with the sick, the thermometer requires most careful disinfection after use. In hospital practice this is most easily and efficiently done, for as soon as the temperature is noted the instrument is at once placed bulb downwards in a small vessel of carbolic lotion, or similar disinfecting fluid. It is notoriously more difficult to carry out antiseptic precautions in private practice, though, happily, it is becoming less so, still, the busy practitioner often has to be content with hastily dipping the bulb of the thermometer in water and wiping it upon a towel or handkerchief, whereupon it is dropped back into its case in a condition which, in the great majority of instances, cannot be said to be aseptic. Many attempts have been made to get over the difficulty, but one of the best is that of putting a few drops of formalin into the case, as was suggested by Dr. W. H. Dyer. That this antiseptic is really powerful in preventing the growth of organisms when employed for this purpose has been recently demonstrated by Dr. F. P. Denny, (a) who has elaborated a series of bacteriological tests, the outcome of which shows that two or three drops of formalin inserted once a fortnight into the thermometer case are quite sufficient to disinfect the bulb and to keep it in a fit state for use.

#### PERSONAL.

MR. G. H. MAKINS presided over a brilliant gathering on the occasion of the South African Civil Surgeons' Dinner at the Hotel Cecil on the 28th ult.

(a) *Boston Med. and Surg. Journ.*, June 2nd, 1904.

THE Earl of Radnor will preside at the Congress of the Royal Institute of Public Health, to be held at Folkestone from July 21st to 26th.

DR. RENEY SMITH is President of the Medico-Psychological Association of Great Britain and Ireland, which meets on July 21st and 22nd at Chandos Street, London.

SIR JOHN WOLFE-BARRY distributes the prizes at King's College, London, this afternoon (July 6th).

DR. JOHN BEDDOE, of Clifton, will deliver the first of the annual lectures instituted at the Bristol Medical School in memory of the late Dr. E. Long Fox.

DR. J. G. DOUGLAS KERR, of Bath, is the owner of the *Valdora*, the winner of the cup in the recent Heligoland yacht race.

SURGEON-LIEUTENANT-COLONEL GASKELL, V.D., J.P. on June 23rd last formally handed over to the Mayor and Corporation of St. Helens the grounds which he has presented to his fellow-citizens, to be known as the Gaskell Park.

THE appointment of Mr. Otho Galgey, M.R.C.P.I., as official member of the Legislative Council of St. Lucia, has been approved by His Majesty the King.

THE Duchess of Albany will open the new ophthalmic out-patient department at the Royal Hospital, Richmond, on July 8th.

DR. J. LORRAIN SMITH, Professor of Pathology in Queen's College, Belfast, has been elected President of the Ulster Medical Society for the ensuing year, 1904-5.

THE Duchess of Albany last week paid a visit to the Royal Hospital for Incurables, Putney, for the purpose of opening the annual sale of work held there for the benefit of the Institution.

PRINCESS CHRISTIAN was present on June 28th at a meeting of the National Health Society, held at the Mansion House, London, and presented certificates and diplomas to those who had been successful in the annual examinations.

THE Duke of Argyll presided on the 28th ult. at a meeting, held by permission of Eleanor Lady Trevelyan, at 67 Eaton Square, S.W., in support of the Metropolitan Provident Medical Association.

SIR CHARLES TUPPER, the veteran ex-Premier of the Dominion of Canada, in his early youth was engaged in medical practice for a short period of his career.

PROF. ROBERT KOCH has been elected a member of the Berlin Academy of Science in succession to the late Prof. Virchow. The *Berliner Tageblatt* states that Prof. Koch has resigned the post of Director of the Berlin Institute for Infectious Diseases.

THE Wightman Lecture of the Society for the Study of Disease in Children will be delivered by Mr. R. Clement Lucas, B.S.LOND., F.R.C.S., at the Victoria Hall, Hotel Cecil, on Friday, July 15th, at 6.30 p.m. The title of the lecture is "The Hereditary Bias and Early Environment in their Relation to the Diseases and Defects of Children." The lecture is open to all members of the medical profession.

Disease of heart	1,518
Disease of veins	1,078
Loss or decay of teeth	4,316
Defects of lower extremities	1,075
Flat feet	1,090
Malformation of chest and spine	395
Under height	1,015
Under chest measurement	4,969
Under weight	1,903

The total number of rejections was increased on

(a) *Practitioner*, June, 1904.



**Special Correspondence.**

[FROM OUR OWN CORRESPONDENTS.]

**SCOTLAND.**

**EPIDEMIC OF SORE THROAT AT BELVEDERE FEVER HOSPITAL.**—During about three weeks of May there was an outbreak of sore throat involving thirty-nine persons, mostly members of the staff, in this hospital. A bacteriological examination showed that in two-thirds of the cases from which swabs from the throat was taken, the organism present was Loeffler's bacillus, sometimes in almost pure culture. The outbreak was clearly due to milk infection, for an organism with the same microscopic and cultural characters was isolated from a sore on the hand of one of the milkers at the farm from which the milk supply of the hospital is obtained.

**TREATMENT OF INFECTIOUS DISEASES AT MONTROSE.**

—In the last annual report of the medical officer of health it is stated that while twenty cases of scarlet fever were removed to the fever hospital, ten of diphtheria and four of typhoid were sent to the infirmary. Dr. Connor explains that the removal of the patients to the latter institution was necessary on account of the skilled nursing required, but points out the desirability of having such arrangements made at the Fever Hospital as would enable him to treat all infectious cases there. In consequence of this report the Local Government Board caused inquiry to be made, and the results of this inquiry, communicated by the secretary, were under the consideration of the Town Council on June 6th, and were remitted to the Public Health Committee. From the strictures of the Local Government Board's medical officer it would seem that a good deal is needed before it can be said that infectious disease is being properly dealt with in Montrose. The person in charge of the Fever Hospital is not a trained nurse, and although many cases of scarlet fever may in their issue prove to have been of little gravity, the local authority ought to fix the standard of attendance to meet the necessities of the grave cases which may occur, not those of the mildest. The arrangements for the treatment of enteric fever and diphtheria in the infirmary are the result of use and are the faulty expedients of bygone days which are totally opposed to present experience. Patients and their friends have, in Sir Henry Littlejohn's opinion, just cause of complaint as to the danger which medical and surgical cases run from their proximity to infectious cases in the wards. A separate ward containing two beds is set apart near the operating theatre for diphtheria cases; this is done for convenience should an operation be needed. For tracheotomy, however, the elaborate arrangements of a modern theatre are unnecessary, and to operate on a dangerous infectious disease in a room filled with all the requirements of modern surgery for the prevention of infection in ordinary operations defeats the purpose of these precautions, and therefore is reprehensible. The Board trust that the local authority, having at present no accommodation for infectious disease, of which the Board can approve, will at once staff and equip the Fever Hospital so as to make it suitable for the proper treatment of all the cases of infectious disease for which they are responsible.

**SIDLAW SANATORIUM, DUNDEE.**—The buildings have now been completed by ex-Provost Moncur's liberality in providing a well-equipped sanatorium at a cost of £25,000. During the first year of the sanatorium's existence, eighty-seven patients were admitted, the average sojourn being close on four months. Excluding seven cases which were only under treatment for a month, the disease was arrested in twenty-four, and improved in twenty. At present the finances compel the directors to fix the charges at a minimum of £1 per week; but to benefit the working classes, considering that a residence of six months is desirable, they ought to be able to admit at from 5s. to 10s. weekly. This would do much to enhance the usefulness of the institution by inducing cases to come early enough and to stay long enough to have a good chance of being

cured. The directors therefore appeal to the wealthy to help them by endowing the sanatorium.

**BELFAST.**

**ULSTER MEDICAL SOCIETY.**—The annual meeting of this society was held on Thursday last in the Medical Institute, Belfast. The President, Dr. John Campbell, F.R.C.S., in the chair. The report of Council moved by Dr. Houston and seconded by Dr. Calwell, showed that the Society is in a very flourishing condition, the total number of Fellows and Members being 197. The report stated that during the past year steps had been taken to procure a bust of the donor of the Institute, Sir William Whitla, and to this end a commission had been given to Miss Kathleen Shaw, who had nearly completed the work. The financial statement was presented, and its adoption moved by the Hon. Treasurer, Dr. W. B. McQuitty, and seconded by Professor Byers. From this it appeared that the annual income of the Society from members' subscriptions is about £300, and that in addition to this several members had contributed special donations amounting in all to £109 to aid in the improvement of the Society's library. The sum expended on books and periodicals during the year was £136. At the close of the financial year a sum of £50 was invested, and a balance of £152 remained in hand. The Hon. Librarian's report was read by the Hon. Secretary, in the absence of Dr. R. R. Leatham, and was seconded by Dr. Nelson. It drew attention to the recent division of the library into consulting and lending departments, the latter being designed largely for the benefit of country members. The following office-bearers for the session 1904-1905 were elected:—President, Professor J. Lorrain Smith; Vice-Presidents, Dr. Hadden (Portadown) and Dr. J. B. Moore (Belfast); Hon. Secretary, Dr. Thos. Houston; Hon. Treasurer, Dr. W. B. McQuitty; Hon. Librarian, Dr. R. R. Leatham; Members of Council (in addition to the seven trustees), Drs. D. P. Gausson, J. R. Davison, J. Hall, D. J. McKinney, J. S. Morrow, and W. L. Storey. Dr. J. C. McCarroll (Carrickfergus) and Dr. William Mair (Queen's College, Belfast) were elected Fellows of the society.

**THE GORDON PORTRAIT.**—At the conclusion of the ordinary business an interesting function took place, a portrait of the late Dr. Gordon, Professor of Surgery in Queen's College, being presented to the society by his daughter, Mrs. Gordon Stallard. In the absence of that lady through illness, the portrait, which was hung in the large hall of the Institute, was unveiled by Mrs. John Campbell. Sir William Whitla, who made the presentation for Mrs. Gordon Stallard, spoke of the suitability of this home for the portrait, where it looked down on so many who had been pupils, and some who had been friends, of the great surgeon and teacher. The President of the Society, in receiving the portrait, said that Dr. Gordon had been not only a member, but also a president of the Society, and on that account, as well as for his world-wide reputation, he welcomed the gift of this portrait. Professor Sinclair, Dr. Gordon's successor in the chair of surgery at Queen's College, moved a vote of thanks to Mrs. Gordon Stallard on behalf of the Ulster Medical Society. Dr. Gordon was, he said, more than a name, even to the younger members of the Society, for the great principles he enunciated have been passed on by his successors. Dr. Gordon's power as a teacher he believed to be due to his rigid self-criticism before laying down any surgical principles. No one who had known him could forget his almost childlike glee over some new observation he had made, and his heart-whole devotion to his profession. Those who had been privileged to know him held him in the warmest esteem and affectionate regard. Dr. Joseph Nelson, as senior trustee, seconded the motion. When a student he had lived as a member of Dr. Gordon's household for two years, so that his knowledge of him was very intimate, and he endorsed all that Professor Sinclair had said. Dr. Henry O'Neill also spoke.

**SMALL-POX IN BELFAST.**—The past week shows some improvement as regards the number of new cases of

small-pox in the city, as only four were found and removed to the Small-pox Hospital at Purdysburn. One of these was the wife of a medical man practising in the Ballymacarrett side of Belfast, who had attended some of the previous cases. The others were all in one house, and will probably be the starting point of further cases, for two unvaccinated children had been ill for a fortnight or more, and it was only when the father also became ill that the facts came to light. There can be little doubt that the people were quite aware of the nature of the disease, and tried to conceal it. One of the cases in hospital died during the week; all the others are doing well. At a meeting of the Belfast Corporation held last week it was stated that the total admissions to the Small-pox Hospital up to date, since the beginning of the outbreak, were 93. There were 55 discharges, 2 deaths, and 36 patients remained in hospital. At the intercepting hospital on the Twin Islands, 302 people had been provided for, of whom 94 still remained, 21 cases having contracted small-pox. At the same meeting Alderman King Kerr, M.D., gave some interesting facts about vaccination and its effects, as seen in this epidemic. In the case of one family, which had been exposed to infection, six were revaccinated and two refused; the six escaped and the two took small-pox. In another case there were 40 contact cases, of whom 39 were revaccinated and one disappeared to avoid it. Later on he reappeared with the disease, the other 39 having escaped! Not a single revaccinated case has been seen at the Purdysburn Hospital.

### Correspondence.

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

#### SANITARY AND BUILDING BYE-LAWS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A little space in your influential journal to suggest that our municipal and borough councils make obligatory the use of some kind of approved exhaust ventilator on soil-pipe air-shafts. Whatever the supposed virtue of the wire balloon may have been originally, it is always found to allow "blowdown" at any seaside place or district where gusty winds are frequent. Something better, too, is required than a cowl that merely permits escapement or prevents blowdown, but does not promote an efficient updraught.

Our sanitary bye-laws should also require all closets or bathrooms to be painted. Paper absorbs and retains foul air and is a not unlikely source of infection. Again, ordinary roofs, other than mansards, should be provided with at least one turret ventilator and top floors or landings be ventilated with Tobin tubes. Otherwise the upper parts of the house will receive and retain the exhausted fumes from the kitchen and house generally. An "outlet" ventilator should also be required in the external walls of rooms not provided with a fireplace and an exhaust ventilating shaft to all kitchens, sculleries, bathrooms, and lavatories. These methods are especially necessary at seaside places owing to the difficulty in securing ventilation without draught or disturbance due to the high and variable winds. There is no reason why most of our seaside towns should not rank amongst the healthiest of health resorts if only sanitary regulations of this sort were rigorously enforced.

It is also time that builders and building owners constructed their houses for some definite purpose. An advertisement prior to building, inviting the requirements of prospective buyers or tenants, would be sufficient. At present they build something that may (or may not) suit as a private house; a boarding house, a private hospital, a boarding school, &c., &c., result, dismal discomfort; one or two medium-sized and a large number of small, draughty, wrongly lit, uncomfortable rooms describes most of our modern houses. Whereas if they were built for some definite purpose, adapted to the special needs of the neighbourhood, they would be suited to the requirements of each

case and the occupiers would be comfortable. For example, there are places where boarding houses are in special demand. Or again, places famous for a cure for some particular ailment. Invalid visitors to such places unable to climb stairs, &c., should be provided with ample accommodation on the ground floor. The stock private or residential house cannot meet both of these cases. Our Continental cousins have long since solved this difficulty with the result that each class of visitor is made happy. Our seaside resorts suited to invalids and holiday folk alike would largely benefit by such special structures.

I am, Sir, yours truly,

MODERNUS.

#### ST. GEORGE'S AND HOSPITAL CENTRALISATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your leader of June 29th on the above subject is practical and to the point. You very properly state "there is no poor population close at hand—and domestic servants furnish a considerable proportion of the patients attending the institution." We all know that domestic servants everywhere, more especially the West End of London, enjoy higher wages than ever. Why, then, should a hospital be kept for persons who earn £25 to £40 per annum, besides board and lodging, and most likely never give any contribution to the hospitals whatever? Surely this is an additional instance of hospital abuse. Numbers of people subscribe to the hospitals under the delusion they are helping the very poor, who alone should have the benefit, and yet the pampered menial in receipt of £30 or £40 a year will take advantage of free advice and medicine at the expense of the ignorant philanthropic public who think it a salve to their conscience when about to die to leave their money to hospitals, little knowing how badly it will be applied. It will be a just judgment on selfish hospital boards when your prognostication comes true (as it assuredly will), and the "outer metropolis builds its own hospitals," leaving St. George's and others severely alone.

I am, Sir, your truly,

WEST END.

#### PROPOSED STERILISATION OF CERTAIN DEGENERATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—IN THE MEDICAL PRESS AND CIRCULAR of June 29th, a correspondent asks if my proposal to sterilise certain degenerates is "merely academic." Certainly not. All our present efforts to check lunacy and other forms of degeneracy have failed lamentably. The Lunacy Commissioners recognise this. If it were not for the large and increasing number of suicides, we should—even in this country, where new ideas and change are repugnant to nine-tenths of the people—have been compelled to take action. I fear a number of correspondents have failed to read my work. I have given away 360 copies, while it has been published on a purely charitable basis. Those "who have honoured me" (is not this the usual jargon?) by reading it, will note that I refer only to the question of *degenerates begetting offspring*. I do not propose any interference with their marriage even. I only contend that there are certain named degenerates who have no right, moral or social, to curse an offspring with their disease, or to burden the ratepayers by supporting them. In my work, one case is referred to where an imbecile woman was confined of nine children by a partly imbecile father. It has lately been pointed out that in a work-house in Yorkshire five unmarried imbecile women have been confined of fifteen children. And yet even we doctors rant and cant about degeneration, and with an unctuous hypocrisy wonder why these things are allowed to develop. In the same way we allow persons removed from asylums to resume conjugal relations or to marry. Why? Is this the right thing to do? If not, why do we fail to take action? But what can the ordinary medical do when a man of the professional

standing and ability of Dr. Mercier attempts to ridicule the whole question and to switch it off on to the tracts of india ink marks. Surely life is too serious, and the present condition of lunacy too grave to joke about.

I am, Sir, yours truly,  
ROBERT R. RENTOUL.

Liverpool.

#### LUNACY—A PRACTICAL DEFINITION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As once a lecturer on legal medicine and induced for various reasons to study legally and clinically the subject of lunacy, I have ventured to draw your attention to it. I cannot agree with Dr. Clement H. Sers that we are sometimes provoked "to shake our fists in the face of any bullying counsel." The way in which I have seen members of my profession refuse to certify in such cases, and far worse ones, as the Archdeacon's brother has impressed me frequently; and I must say that I have always found in a Court of Law a far higher spirit of justice and good feeling among those conducting the legal business than among those engaged on either side, in matters medical. The question that a doctor has to decide when he is called upon to give an opinion on the mental condition of the patient is simply this: Is this person in a condition that frees everyone from responsibility in regard to his actions, and can he be trusted to do no injury to himself or to others by the derangement of mind to which he is temporarily or chronically subject?

If that person has property the lawyer naturally takes greater interest in the case than if he is a pauper. The interests of the patient must be considered on the one hand and the interest of the community in which he lives on the other. We have to distinguish very clearly when we are called upon to certify whose interests have most to be considered. In such a case as the Archdeacon's brother, a lawyer would perhaps take the view that other people can be left to take care of themselves, till crime has brought the lunatic within reach of the law. When we see a poor feeble-minded person who controls valuable property being influenced in an unfair way in the management and disposal of it, we are justified for the good of that person, and in the interests of others, in certifying. The lawyer would be the first to agree with that view, particularly if the patient were a woman. Can this person be treated badly by others, or influenced badly by them? On the other hand, can this person be dangerous to others? These are the simple questions that a doctor ought to be called upon to answer when asked to certify. If he cannot answer, at once and satisfactorily, these questions, he ought to certify accordingly, and let his opinion be handed on to those who can properly deal with it. The doctor has no personal interest in such a case, or ought not to have, and no responsibility. This is all that the law requires, and we need have no fear that a "doctor" will be bullied by a lawyer when he gives his honest and impartial opinion in a case of lunacy.

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

### Literature.

#### SQUIRE'S POCKET COMPANION.(a)

THIS is a new book evolved—Phoenix-like—from the ashes of an old and famous volume. It is new in the sense of fresh arrangement and of added and excised matter, but old in the solid familiar outlines of Squire's classical "Companion to the Pharmacopœia" which has outlived several medical generations. The present book has been compiled principally for the use of medical men, and it is the only book of the kind which contains all the official substances together with all the non-official substances which are of any importance, arranged in alphabetical order throughout. The

(a) "Pocket Companion to the British Pharmacopœia." By Peter Wynt Squire. London: J. and A. Churchill, 1904.

apparent exceptions to this arrangement are the grouping of several preparations under one heading, such for example as the new silver salts under "Argenti Nitras," where they can be more conveniently compared than would be the case if they were distributed through the book under the initials of their fancy names. The non-official substances which have not fulfilled original expectations are mentioned collectively in small type under the substance to which they most nearly relate. The paragraphs "Prescribing Notes" originally introduced in the "Companion" have been largely increased both in number and in extent, and add considerably to the value of the book. The solubilities and methods of prescribing are written from the results of actual experiments instituted for that purpose by a special staff that has been engaged upon the work for two years. Other practical notes of a similar nature are also scattered throughout the work, and indeed the guiding principle of utility is everywhere apparent. The references to medical literature are very complete and in one instance that of "Soda-Chlorinatæ Liquor," page 573, A.J.P. 1904, 266 bears the date of June, 1904.

When the preparations official and not official of any substance occupy many pages a saving of time will be effected by reference to the list "Official Preparations" and "Not Official" which are given under the Dose or Prescribing Notes of the principal substance.

As an up-to-date book of ready reference for the consulting room table of any medical man, be he consultant or general practitioner, Squire's "Pocket Companion" would be hard to beat.

#### INFECTIVITY OF ENTERIC FEVER. (a)

IN this octavo pamphlet of forty-seven pages, the writer endeavours to show cause for a revision of our views on the etiology of enteric fever. He tells us that his "aim is to demonstrate that enteric fever is an infectious disease, communicable by direct personal intercourse, just as typhus fever is; and that explanations of its origin from drinking water have, in several instances, failed in the ablest hands." Dr. Collie writes with great clearness and force in support of this thesis. His work is, of course, an iconoclastic attack on a quasi-scientific position which would appear to have been regarded by the great majority of the medical men of one generation as practically impregnable. Under such circumstances we do not consider it our duty to enunciate our own private views in form of an *ex cathedra* opinion; which would almost surely have no other effect than that of adding a new element of discord to a discussion which cannot fail to promote the dissemination of further knowledge, without, at the same time, convincing the holders of either view. Accordingly, we will merely observe that Dr. Collie's facts and arguments show that the defenders of the older position have to deal with a skilled and well-armed opponent. We shall, ourselves, look forward with interest to future revelations and arguments. In the meantime, the increased caution which they tend to promote cannot fail to have a general good effect.

#### STEVENS' PRACTICE OF MEDICINE. (b)

THIS manual, which has been before the profession for many years, is by an American author, and has now reached its sixth edition. The chief object of the book is to present students with an outline of the subject which may be expanded by theoretical and clinical lectures. Bearing this fact in mind, we do not expect to find the work overloaded with details; in fact, the complaint in this country would generally

(a) "The Infectivity of Enteric Fever: with Observations on its Origin and Incidence at Caius College, Cambridge, Festiniog and Wicken Bonant." By Alexander Collie, M.A. Aberd., late Clinical Instructor at the Eastern Hospitals. &c. Bristol: John Wright and Co. 1904.

(b) "A Manual of the Practice of Medicine. Prepared Especially for Students." By A. A. Stevens, A.M., M.D., Professor of Pathology in the Woman's Medical College of Pennsylvania. &c. Sixth Edition, Revised and Enlarged. 10s. 6d. net. Philadelphia and New York: W. B. Saunders and Co. 1903.

be of its brevity, detailed description being, in many parts, inadequate for a student preparing for examination. That this is so may be readily seen by glancing over any of the descriptions of diseased conditions. Thus, rheumatic fever has four pages devoted to its consideration, pulmonary tuberculosis eight, aortic aneurysm three, and alcoholism two respectively. Interspersed throughout the book, however, are numerous simple and useful prescriptions, a feature which will prove very helpful to junior practitioners. Seventy pages are devoted to diseases of the skin, and this is, in our opinion, a wise addition, as we have often had to complain of the absence of their mention in other manuals intended for the use of students. This edition has been carefully revised and enlarged, so that in its new form it really enters upon a fresh lease of life, which, we doubt not, will be a long one.

#### COSTA'S MODERN SURGERY. (a)

THE fourth edition of this book has been revised and brought up to date. In the treatment of the various forms of aneurysm, the author gives in the case of the large arteries, the history of the first operation, then the anatomy of the vessel, and methods of treatment, and finally the results. This section is interesting and complete. In the treatment of tuberculous disease of the hip, when rest and fixation of the joint fail to cure, he recommends the use of intra-articular injections of iodoform and glycerine, saying, "always try these injections before doing a resection," and "it may be necessary to give from ten to twenty injections." As these injections are given once a week this may require a prolonged treatment, and, it seems to us, the risk of such a number of injections would equalise that of resection—we certainly prefer resection as soon as rest and fixation fail. Section XXVII, dealing with "Diseases and Injuries of the Abdomen," is very complete, and the various lesions and operative measures are fully discussed, the various operations on the stomach and intestines being particularly well dealt with. In the section on "Diseases and Injuries of the Rectum and Anus," the treatment of fistula seems to have been overlooked in the revision of the book, for we find no reference to excision and suture of the diseased tract, which method, in suitable cases, greatly shortens the after-treatment. In the treatment of pruritus ani, the author says, "In very severe cases touch with a solution of silver nitrate (1-10), employ the Paquelin cautery, or resect the mucous membrane as in Whitehead's operation for hæmorrhoids." We fail to see how the latter will be of use, as the disease in these cases is entirely outside the mucous membrane. On the whole, this book is complete, pleasant to read, and one of the best single volume surgical works we have come across.

#### NEW BOOKS AND NEW EDITIONS.

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

- EDNEY APPLETON (London).  
Clinical Lectures and Essays on Abdominal and other Subjects. By H. D. Rolleston, M.A., M.D., &c. Pp. 178. Price 5s. net.
- BAILLIÈRE, TINDALL AND COX (London).  
Lectures on Clinical Psychiatry. By Dr. Emil Kraepelin. Authorised Translation from the German, revised and edited by Thomas Johnstone, M.D. Edin., M.R.C.P. Lond. Pp. 308. Price 10s. 6d. net.
- Questions and Answers on Midwifery for Midwives, with Syllabus of Lectures for the "L.O.S." By A. B. Calder, M.B., M.R.C.S. Pp. 143. Price 1s. 6d. net.
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(a) "Modern Surgery." By J. Chalmers de Costa, M.D. Fourth Edition, enlarged. Price, 21s. net. Philadelphia: W. B. Saunders and Co.

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International Clinics. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia. Vol. I. Fourteenth Series, 1904. Pp. 304.
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- A Manual of Practical Ophthalmology. By George A. Berry, M.B., F.R.C.S. Ed. Illustrated. Pp. 570.
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A Text-book of Clinical Anatomy for Students and Practitioners. By Daniel N. Eisenbrath, A.B., M.D. Illustrated. Pp. 515. Price 21s. net.
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- Golden Rules of Anaesthesia. By R. J. Probyn-Williams, M.D., Pp. 67. Price 1s.

#### Obituary.

ALFRED ELLIS VAUGHAN, L.R.C.P. ED.  
The death is announced of Dr. Alfred Ellis Vaughan, L.R.C.P.E., etc. He was medical officer for the Haslington poor-law district, was surgeon to the Lord Crewe Court of Foresters, and held other public positions. He was educated at Owens College, Edinburgh, and Glasgow, and took the diploma of the Edinburgh Physicians in 1898.

#### Plague Figures.

Up to July 6th, there have been 27 cases of plague among whites and 120 among coloured people. Thirteen whites and 83 coloured people have succumbed to the disease. The last previous statement as to beri-beri showed that there were 40 cases.

## Medical News.

### Annual Meeting of the British Medical Association.

The annual meeting of the Association at Oxford on July 26th, 27th, 28th, and 29th, will be inaugurated by a service in Christ Church Cathedral at 10.30 o'clock, when the sermon will be preached by the Rev. James Franck Bright, D.D., Master of University College. The first general meeting of members will be held on Tuesday, July 26th, at 12 o'clock noon, to be followed by the representative meeting. At 8 o'clock the President, Dr. Collier, will receive the Colonial and foreign guests in the Sheldonian Theatre, and deliver his Presidential Address. On Wednesday, honorary degrees will be conferred in the Sheldonian Theatre, and at 2 o'clock the general meeting will resume its session to consider where the association shall meet in 1905, and to nominate the President-elect. At 8 o'clock Sir William Selby Church, Bart., K.C.B., M.D., D.Sc., will deliver an address in medicine in the Sheldonian Theatre. On Thursday at 2 o'clock, Sir William MacEwen, M.D., F.R.C.S., LL.D., will deliver an address in Surgery in the Sheldonian Theatre. At 7.30 the dinner of the Association will be held in the Hall of Christ Church. At 8 o'clock a popular lecture will be delivered in the Town Hall by Dr. George Bagot Ferguson, F.R.C.S., M.Ch.Oxon. On Friday at 2 o'clock the representative meeting will again sit should it not have completed its work. On Wednesday, Thursday, and Friday from 10 a.m., to 1 p.m., the following fourteen scientific sections, viz., medicine, surgery, obstetrics and gynaecology, state medicine, psychological medicine, pathology, physiology, anatomy, ophthalmology, dermatology, laryngology and otology, tropical diseases, navy, army, and ambulance, dental surgery, will meet in the University Museum Buildings, the work promising to be of special interest. Much hospitality will be offered to members. On Wednesday the President and members of the Oxford Division will hold a reception in Wadham College gardens, while in the evening the Vice-Chancellor and members of Oxford University will give a *soirée* in the Museum. On Thursday there will be garden parties in the afternoon and in the evening an entertainment in New College. On Friday afternoon the Duke of Marlborough will receive a limited number of guests at Blenheim Palace, and in the evening the Mayor of Oxford, Mr. E. A. Bevers, M.R.C.S., will hold a reception in the City Buildings. For Saturday various excursions have been arranged to places of interest round Oxford.

### The Congress of the Royal Institute of Public Health at Folkestone.

THE meeting of the Royal Institute of Public Health will be held at Folkestone from July 21st to 26th, under the presidency of the Right Hon. the Earl of Radnor. Dr. W. J. Simpson and General Sir William Stirling, K.C.B., preside over the sections of Tropical Medicine and the Early Physical Training of the Imperial Forces. Papers will be read and discussed by Mr. James Cantlie, Colonel A. Crombie, C.B., I.M.S. (retired), Brigade-Surgeon-Lieutenant-Colonel W. Hill Climo, A.M.S. (retired), Surgeon-General G. J. H. Evatt, C.B., A.M.S. (retired), and Brigade-Surgeon-Lieutenant-Colonel James Turton, A.M.R. In the section of Comparative Pathology, Bacteriology, and Chemistry Dr. Edward E. Klein, F.R.S., the president, will deal with "The Aim and Scope of Bacteriological Analyses of Water and Shell-fish with Reference to Sewage Pollution."

### The Medico-Psychological Association of Great Britain and Ireland.

DR. R. PERCY SMITH will preside at the sixty-third annual meeting of this association, to be held on July 21st and 22nd, at 11 Chandos Street, Cavendish Square, W. On July 21st, at 2 p.m., the President will deliver his address, after which Dr. G. E. Shuttleworth will read a paper on "The Education and Treatment of Young Epileptics," and Dr. C. Hubert Bond, a paper on "A Plea for the Closer Study of the Bodyweight and its Relation to Mental Disease." On July 22nd, at 10 a.m., papers will be read by Dr. A. W. Campbell

and Dr. John Turner dealing respectively with "Further Histological Studies in the Localisation of Cerebral Function and the Finer Anatomy of the Nervous System with Special Reference to the Doctrine of Continuity." "The Psychology of Hallucinations" will be introduced by Dr. W. H. B. Stoddart. Papers dealing with "The Care and Treatment of the Insane," will be read by Dr. G. M. Robertson, Dr. J. Milson Rhodes, and Mr. J. Carswell, at 2 p.m. On the evening of July 21st, the annual dinner will be held at the Whitehall Rooms of the Hotel Métropole, and on July 22nd, from 4 p.m., to 7 p.m., the President and Mrs. Percy Smith invite members of the Association to a garden party at the Botanical Gardens, Regent's Park, N.W. Tickets for the dinner can be obtained from the honorary secretary, Dr. Robert Jones, price one guinea, including wine.

### A False Certificate.

AT Hampshire Assizes on Saturday, Charles Hustwick was sentenced to eighteen months' hard labour for giving a false certificate as to an infant's death. It was stated accused had acquired some medical knowledge and posed as a doctor. He had previously been sentenced to five years' penal servitude for an illegal operation. He had also adopted a name found in the "Medical Register."

### Small-pox at Stockport.

THE week before last, twenty-one cases of small-pox were reported in Stockport. The majority of the cases were traced to the lower part of the town, where a child was visited by a number of neighbours, whilst suffering from the disease, which was wrongly thought to be measles. St. Paul's Church, Heaton Moor, was closed on Sunday, owing to the apparitor's wife having been attacked by small-pox. The church will be disinfected prior to being reopened. This serious invasion of Stockport is naturally causing a good deal of alarm locally.

## PASS LISTS.

### Trinity College, Dublin.

THE following candidates passed the examinations indicated during Trinity Term, 1904:—

*Anatomy and Institutes of Medicine.*—John C. P. Beatty, Francis R. Coppinger, Robert E. Wright, Thomas J. Cobbe, Thomas H. Peyton, John W. Tomb (*passed on high marks*); Charles T. Atkinson, Richard Connell, Richard G. S. Gregg, Gustav W. Thompson, Theodore C. Somerville, Charles G. Sherlock, Reginald Holmes, Thomas L. de Courcey, Henry D. Drennan, Dudley S. Torrens, Edward, C. Stoney, Herbert J. Wright, Malcolm K. Acheson, William Hutchison, Robert B. Jackson, George E. G. Vickery, Francis Casement, Francis W. H. Bigley, Ernest Jameson, Ernest D. Caddell, Edward Evans, William A. Nicholson.

*Physics and Chemistry.*—Richard P. Hadden (*passed on High Marks*); Charles F. F. Davies, William R. G. Atkins, Ernest C. Lambkin, Dixie P. Clement, Johannes C. Pretorius, Robert V. Dixon, James F. Clarke, Douglas M. Moffatt, Robert G. Orr, William E. Hopkins, Frederick A. Anderson, Gerald McCreedy, Henry H. Ormsby, Samuel F. A. Charles, Norman Jewell, Charles W. Laird, James D. Murphy, John L. Phibbs, Albert V. Richardson, Harold S. Sugars, Richard J. Attridge.

*Botany and Zoology.*—Ralph T. Brooks, Arthur H. Land, Ernest C. Lambkin (*passed on High Marks*); Charles F. F. Davies, Richard P. Hadden, Albert J. Stals, William E. Hopkins, Charles W. Laird, Charles G. S. Baronsfeather, Henry R. Kenny, Johannes C. Pretorius, Dixie P. Clement, Frank N. Smart, Robert E. T. Tatlow, Douglas M. Moffatt, John L. Phibbs, William R. G. Atkins, Thomas P. S. Eves, William Knapp, George H. Stack, James Brereton-Barry, Gordon A. Jackson, Norman Jewell, Alfred H. Smith, Alexander S. Winder, James Beckett, Derrick W. Knight, John T. M'Donnell, Kenneth Smith, Cecil Grene, Frederick C. Newland.

*Diploma in Public Health.*—Parts 1 and 2, Alexander H. Marks.

## 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.

**SHREWSBURY**.—The original error lay in employing a chemist to take the radiogram of your patient's shoulder instead of a skilled medical operator. A chemist's knowledge of anatomy, both surgical and pathological, is *nil*, and his evidence in a court of law would be worthless. On the other hand the medical X-ray expert is often able to give information that is essential to the proper treatment of a given case and to furnish evidence incontrovertible in a court of law.

**CLIFTONIENSIS**.—Skipping as an aid to health is clearly not available for more than a certain proportion of mankind. You had better consult Dr. Bond, of Gloucester, upon the subject. He is the apostle of this modern cult.

**DR. T. FRENCH**.—The invitation to furnish contributions on special subjects, of a medical nature, to lay journals should be declined in all cases where the object is to provide professional advice with a view to displacing the services of a medical man.

**MR. COOPER JOHNSTON**.—The organisation of a street ambulance system is one that you would do well to take up locally. There is abundant room, nay, an urgent need in most provincial centres for something of the kind. There can be no doubt that a vast amount of human suffering and to some extent of life itself would be prevented if the means of speedy removal of the sick and injured were at hand in all of our great towns. There is a good deal to be said in favour of a co-operation between the philanthropists and the police and the fire brigade services.

**M.R.C.S. (Meltonian)**.—The sea-side is not likely to do any injury to the chronic skin condition you mention. If you have any doubts on the point, send your patient to a consultant.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 6th.

**OBSTETRICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Lewers, Dr. Purslow, Dr. Sikes, Dr. Tate, Mr. A. Doran and Dr. H. Williamson, Dr. V. Bonney, Dr. Handfield-Jones, Dr. F. Taylor. Short Communication:—Dr. E. Boxall: Case of Inverted Uterus, Spontaneous Re-position. Paper:—Dr. Pembrey (introduced by Dr. A. Kouth) and Mr. G. B. Smith: (In Sacs containing Fœtuses and lying free in the Peritoneal Cavity of a Rabbit.

THURSDAY, JULY 7th.

**THE RONTGEN SOCIETY** (28 Hanover Square).—8.30 p.m. Annual General Meeting. Annual Report and Balance Sheet. Election of Officers for the ensuing year.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Dr. F. Price: The Diagnosis of Early Pulmonary Tuberculosis (illustrated by cases). (Post Graduate Course.)

FRIDAY, JULY 8th.

**OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM** (11 Chandos St., Cavendish Square, W.).—Cases will be shown by Mr. J. E. Smyth and Mr. R. S. Batten. Paper: Mr. G. Coats: Lantern Demonstration on Cases of Thrombosis of the Central Vein.

TUESDAY, JULY 12th.

**THE SOCIETY FOR THE STUDY OF INEBRIETY**.—In the Rooms of The Medical Society of London (11 Chandos Street, W.).—4 p.m. Afternoon Meeting. Dr. William G. Sullivan, Deputy Medical Officer H.M. Prison, Pentonville: On "The Criminal Responsibility of the Alcoholic." Each Member and Associate is at liberty to introduce a visitor.

## Vacancies.

**Brecon and Radnor Asylum, Talgarth, R.S.O.**—Assistant Medical Officer. Salary £100 per annum with furnished apartments, board, attendance, and laundry. Applications to the Medical Superintendent.

**The Royal National Hospital for Consumption and Diseases of the Chest, Ventnor.**—Senior Resident Medical Officer. Salary £300 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London. (See Advt.)

**Nottingham Consumption Sanatorium, Mansfield.**—Resident Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Clerk, Mr. Geo. Sheldon, 36A Bridlesmith Gate, Nottingham.

**Combined Sanitary District of West Sussex.**—Medical Officer of Health. Salary £250 per annum, to include all travelling expenses. Applications to A. C. Coole, Solicitor, 9 Carlisle, Horsham.

**East London Hospital for Children and Dispensary for Women, Shadwell, E.**—Pathologist and Registrar. Salary £100 per annum. Applications to Thomas Hayes, Secretary.

**Gravesend Hospital.**—House Surgeon. Salary £100 per annum, with board and residence. Applications to F. H. Stevens, Hon. Secretary, 146 Milton Road, Gravesend.

**Hereford County and City Asylum.**—Senior Assistant Medical Officer. Salary £150 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent.

**London Temperance Hospital, Hampstead Road, N.W.**—Resident Medical Officer. Salary £200 per annum, board, lodging, and washing. Applications to A. W. Bodger, Secretary.

**Metropolitan Asylums Board, Darent, Dartford, Kent.**—Male Assistant Medical Officer. Salary £150 per annum, with rations, lodging, attendance, and washing. Applications to the Office of the Board, Embankment, London, E.C.

**New Zealand—Seacliffe Lunatic Asylum, Dunedin.**—Assistant Medical Officer. Salary £250 per annum, with board, lodging, and washing. Applications to the Agent-General for New Zealand, 13 Victoria Street, London, S.W.

**Nottingham General Dispensary.**—Assistant Resident Surgeon. Salary £180 per annum, with furnished apartments, attendance, light, and fuel. Applications to Secretary, M. I. Preston, Journal Chambers, Nottingham.

**Royal National Hospital for Consumption and Diseases of the Chest, Ventnor.**—Two Assistant Resident Medical Officers. Salary £100 per annum, with board and lodging in the Hospital. Applications to the Secretary, 24 Craven Street, Charing Cross, London, W.C. (See Advt.)

**Royal Orthopedic Hospital, Temporary premises, 55 Bolsover Street, W.**—House Surgeon and Registrar. Salary £200 per annum, without board. Applications to Tate S. Mansford, Secretary. (See Advt.)

**St. Thomas's Hospital.**—Casualty Officer. Salary £100 per annum, with board and residence. Application to the Secretary of the Medical School.

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

**West Riding Asylum, Wakefield.**—Pathologist and Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, washing and attendance. Applications to the Medical Director.

## Appointments.

**GRAY, WALTER GORDON, L.R.C.P., L.M. Edin., M.R.C.S.,** Medical Officer of Health for the Holworthy (Devon) Rural District.

**KEENAN, J. F.,** of Ballinalee, Edgeworthstown, as Certifying Surgeon under the Factory and Workshop Act for the district of Ballinalee, which includes Granard Urban District and Granard No. 1 Rural District.

**MEADE, CHARLES GRAHAM, L.S.A.,** Medical Officer for the Witherside District by the South Molton (Devon) Board of Guardians.

**PALMER, FREDERICK S., M.D., M.R.C.P.,** Assistant Physician to the West End Hospital for Diseases of the Nervous System.

**PARSONS, JOHN HERBERT, B.S., D.Sc., F.R.C.S.,** Ophthalmic Surgeon to the Hospital for Sick Children, Great Ormond Street.

**PRICE, H. VAGUHAN, F.R.C.S. Eng., M.A., M.B., B.C. Cantab.,** Honorary Medical Officer to the Brighton, Hove, and Preston Dispensary.

**RICHARDS, THOMAS, L.R.C.P. Lond., M.R.C.S.,** District Medical Officer by the Cardiff Board of Guardians.

**SHORT, T. SYDNEY, M.D. Lond., M.R.C.P., D.P.H. Cantab.,** Honorary Physician to the General Hospital, Birmingham.

**SIMPSON, LILLIAN G., M.D. Brux., L.R.C.P. & S. Edin.,** Senior Resident Medical Officer to the Canning Town Medical Mission Hospital and Dispensary.

**WILLIAMS, W., M.A., M.D. Oxon.,** Examiner in Preventive Medicine in the University of Oxford.

## Births.

**DARE-BASCOMBE.**—On June 26th, at the Grange, Saffron Walden, Essex, Edith (nee Hastings-Miller), the wife of C. Dare-Bascombe, M.R.C.S., L.R.C.P., of a son.

**MICHELIS.**—On July 2, at 48 Finsbury Square, the wife of E. Michels, F.R.C.S., of a daughter.

**SECKER WALKER.**—On June 29th at Oakwood Grange, Roundhay, Leeds, the wife of H. Secker Walker, F.R.C.S., of a son.

**WIGG.**—On July 1st, at 86 Haverstock Hill, N.W., the wife of James Wigg, L.R.C.P. Lond., of a son.

## Marriages.

**MORTON—LESLIE.**—On July 1st, at St. Stephen's Church, Putney, Philip Sidney, son of Robert Morton, Esq., of 27 Hamilton Terrace, N.W., to Philadelphia Fraser Pinkerton, youngest daughter of the late W. Burnup Leslie, Esq., M.D., of Stonehaven, N.B., and of Mrs. Leslie, 40 Oakhill Road, Putney, S.W.

## Deaths.

**KIRKMAN.**—On July 1st, at St. Stephen's, Southwold, Suffolk, Joshua Kirkman, M.A., late vicar of St. Stephen's, Hampstead, and eldest surviving son of John Kirkman, M.D., of Melton, Woodbridge, aged 75.

**LEPPER.**—On June 26, suddenly, at Southsea, George R. Leeper, M.B., T.C.D., third surviving son of the late Rev. Canon Leeper, D.D., Dublin.

**MURPHY.**—On June 28th, at 5 Thornhill Crescent, Sunderland, the residence of her son, Sarah Murphy, widow of William Chapman Murphy, M.D., aged 90.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, JULY 13, 1904.

No. 2.

## Original Communications.

### THE DIMINISHING BIRTH-RATE.

#### PART I.

By DAVID WALSH, M.D. Edin.,

Senior Physician, Western Skin Hospital, London, W., &c.

THE Inaugural Address of the British Gynæcological Society for the year 1904 discussed the diminishing birth-rate of the United Kingdom, together with "its Causes, Tendency, and Possible Remedy." It was delivered by the distinguished President, Dr. John W. Taylor, of Birmingham, whose remarks have excited widespread interest among all classes of society. Although its subject is by no means purely medical, yet matters of such vital social importance are dealt with that no apology need be offered for presenting a short criticism of Dr. Taylor's arguments and conclusions in the columns of a medical journal.

Dr. Taylor rightly said that his subject was a great one. In spite of that recognition, however, he has surveyed the situation almost entirely from a single standpoint, namely, that of the assumed evils resulting from the artificial prevention of conception. By thus narrowing the field of inquiry he has failed to bring the many sides of an extremely complex social question into view. As a matter of fact, his Address is little more than a plausible but not very convincing piece of special pleading against the unfortunate practices to which he attributes so much of the moral and physical defects of society. The causes and results of the limitation of families, however, must be examined under a far more searching and catholic light than that provided by Dr. Taylor. Many of the issues involved may be discussed entirely apart from either the practices of prevention or the crime of abortion, both of which the moral citizen must unhesitatingly condemn. Nevertheless, however great our desire to place society on a sound footing, if we accept theories and assumptions offhand we may find our well-meant efforts diverted into a Quixotic tilting against windmills.

Dr. Taylor's general statement that the birth-rate of the United Kingdom is steadily declining may be accepted. He shows that the birth-rate has fallen 5.2 per 1,000 persons living during the past thirty years, while the marriage-rate has remained practically stationary. From that point forward, however, his article contains hardly a single proposition that will stand serious examination. His chief assumptions with regard to the falling birth-rate appear to be as follows:—

I.—That the fall in the birth-rate refers solely to married persons.

II.—That among married folk the decline is due almost entirely to the artificial prevention of conception.

III.—That a falling birth-rate necessarily indicates a failure in national prosperity.

IV.—His main conclusion, or, from my point of view, assumption, is that preventive practices are

injurious to the moral and physical well-being of parents adopting them, as well as to non-prevented children of such unions.

In the present brief article I propose, as a medical man, first to examine the above assumptions, and to ask if they tally with the facts of the case; then to discuss the proposed remedies; and, finally, to add a few observations and suggestions of my own. An attempt will at the same time be made to indicate the broad lines on which a comprehensive survey of the ground might with advantage be conducted, although I cannot hope that every side of this intricate question will be exhausted or even opened up.

*Assumption I: That the fall in the birth-rate refers solely to married persons.*—As already remarked, Dr. Taylor's proposition may be admitted when he says that the birth-rate has fallen 5.2 per 1,000 persons living during the past thirty years, while the marriage-rate has been nearly stationary. But when he goes on to infer that the fall in question must be due to some condition affecting married life, he at once plunges into a morass. His figures have not taken into consideration the obvious extra-marital condition of illegitimacy, the results of which are included in the general birth-rate of 5.2. Now, a striking feature of the period he covers is the decrease in the number of illegitimate births in the United Kingdom, for they share in the steady fall from 6.8 per cent. to 3.9 per cent. of the total births during the past fifty years. If this loss of 2.9 per cent. of illegitimate births had not occurred the level of the general rate would stand at the present moment not far off the level of twenty years ago. This may be made clear by the following figures:—

TABLE I.

Illegitimate rate per 1,000 births 20 years ago ..	68
Ditto ditto ditto at present ..	39

Loss from decreased illegitimate births per 1,000 births ..	29
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Present total birth-rate per 1,000 persons living, 29.1.

But if no loss had occurred from the decline in illegitimacy, this rate would have increased in proportion of  $\frac{1,029}{1,000}$

Working this out, we get—

$$29.1 \times \frac{1,029}{1,000} = 29.94 \text{ (or nearly 30),}$$

as the total birth-rate would be at the present moment had there been no falling off in illegitimacy. But in 1884 the total birth-rate stood at 31, so that had not the declining birth-rate affected illegitimacy, we should have had a birth-rate of practically 30 in 1904 compared with 31 in 1884. My figures, I am aware, may not be absolutely accurate, but I think it may be safely concluded that the fall in the married birth-rate is much less than that shown by Dr. Taylor. In a word, his figures are vitiated at the outset by his failure to consider the facts of the extra-marital condition of illegitimacy.

It is impossible, therefore, to accept his fundamental

proposition that "we may take the birth-loss in the United Kingdom as due to causes operating in the married life of its inhabitants."

*Assumption II: That among married folk the decline is due almost entirely to the artificial prevention of conception.*—Before examining the grounds upon which Dr. Taylor forms this conclusion, or assumption, as I prefer to call it in the absence of convincing proof, let us first consider another vitiating factor, namely, the increasingly later age at which marriages take place. True, he mentions this condition, but only to brush it aside somewhat cavalierly in his anxiety to reach his main conclusion. It deserves, in my opinion, far greater weight than he is inclined to attach to it. The age at which a man marries has, or should have, within reasonable limits, but little effect on the prospect of his becoming a father, for if of sound constitution he may beget children at ninety or any other patriarchal age. The average life of civilised man, however, is comparatively short, and hence the influence of late marriage upon fertility is appreciable. One cannot lose sight of the fact, moreover, that a man who marries, say, at thirty-five has already lost some twenty years of active procreative life had he been living under unrestricted conditions. But when the marriage age of woman is taken into account we find a very different state of things. In her case the number of years during which she may expect to become a mother is strictly limited, and decreases with every year of her life until about five-and-forty, the fall in marriage fertility being specially noticeable after twenty-five. Now, as a matter of fact, the age at which women marry in the United Kingdom is becoming rapidly later, for whereas the period 1894-1901 shows a 6 per cent. increase of population, yet, on the other hand, the total number of women marrying under twenty years of age decreased by nearly 300, instead of the increase of many thousands that would have taken place had these under-age marriages continued in their former proportion. These figures are all the more remarkable if compared with the increase of over 32,000 marriages of women between twenty and forty during the same period.

We find, then, that marriage is becoming later in both sexes, a fact that in itself connotes a lessened expectation of children, because the parents' lives are shorter, while procreative power slackens with advancing age in the male and ceases altogether with middle age in the female. The later age at which men marry is doubtless due to the increased difficulty of gaining a footing in life, especially in the learned professions. Men who marry thus later in life are likely, as a broad rule, to marry women of an age somewhat approaching their own, and with correspondingly lessened expectation of child-bearing life, a fact that is well shown in the following table, which was placed before the Royal Statistical Society by Dr. Ogle, in March, 1890:—

TABLE II.  
AGE AT MARRIAGE.

Occupation.	Bachelors.	Spinsters.
Miners .. .. .	24.06	22.46
Textile trades .. .	24.38	23.13
Shoemakers and tailors .. .	24.92	24.31
Artisans .. . . .	25.35	23.70
Labourers .. . . .	25.56	23.66
Commercial clerks .. . . .	26.25	24.43
Shopkeepers and shopmen .. .	26.67	24.22
Farmers and sons .. . . .	29.23	26.91
Professional and independent class .. .	31.22	26.40

This table shows a close relationship between the class of society to which persons belong and the age at which they marry—the better the social circumstances the later the marriage age. The general disparity is most striking when we compare the extremes, which show a difference of seven years in the case of the men and four in that of the women. The marriage age of unskilled labourers is probably much below that of miners and other skilled labourers. The marriage age, again, of such learned professions as that of law and medicine is, most likely, some years beyond that of all professional and independent classes taken together.

If we allow, say, a further margin of four years for unskilled labour at one end of the scale and four years for the learned professions at the other, we have a difference of fifteen years in their respective marriage ages.

The increasing mean age of marriage is well shown in the following tables drawn up in 1874 by Mr. Ansell:

TABLE III.  
RATE OF MORTALITY, LONDON, 1874.  
Period of Marriage.

Years.	Mean Age at Marriage.	Mean Difference in Ages.	
	Bachelors.	Spinsters.	
Before 1840 .. .. .	28.64	24.75	3.89
Since 1840 (to 1874) .. .	29.95	25.53	4.42
Both periods .. .. .	29.31	25.16	4.16

TABLE IV.

Date.	Mean Age at Marriage.	Mean Difference in Ages.	
	Bachelors.	Spinsters.	
1800	27.89	24.30	3.59
1810	28.89	24.52	3.74
1820	28.64	24.74	3.90
1830	29.01	29.94	4.05
1840	29.39	25.1	4.20
1850	29.76	25.41	4.35
1860	30.14	25.64	4.50
1870	30.51	25.84	4.65

The later age of marriage, then, is a factor of prime importance in the decrease of a birth-rate. Taking it along with the fall in the illegitimate birth-rate, we find two conditions sufficient in themselves to account for a good deal—if not the greater part—of the decrease in the general birth-rate of the United Kingdom which furnishes the basis of Dr. Taylor's investigations. The assumed fall of 5.6 in the total married birth-rate is a bubble that collapses when we subtract the illegitimate births. The assumed cause of the decline in the birth-rate of married persons, namely, artificial prevention, collapses also when we apply the test of the later marriage age. Increased continence is not considered worthy of discussion as a possible influence in the decline, either legitimate or illegitimate.

It is clear, therefore, that if Dr. Taylor's foundations are thus insecure, the walls of his superstructure will have little chance of surviving. However, in order to arrive at a basis of argument, we will return to our common point of agreement, that is to say, the admitted fall of 5.6 in the total birth-rate of 1,000 persons living. Similar conditions, it seems reasonable to assume, will ultimately affect the birth-rate both of married and unmarried persons. For instance, if the lessened number of illegitimate births may be ascribed to a generally higher standard of sexual morality, there is no apparent reason why a similar continence should not limit the offspring of married life; or, assuming with Dr. Taylor that artificial prevention is the main cause of limitation, the practice is likely to affect child bearing as regards unmarried women not less than married women.

Dr. Taylor quotes the following figures as the average yearly number of births per 1,000 persons living in Great Britain and Ireland during the

TABLE V.

F.ve-yearly periods.	Birth-rate per 1,000.
1874—1878	34.3
1879—1883	32.6
1884—1888	31.2
1889—1893	29.8
1894—1898	29.1

But he has chosen twenty-five years of steady decline. If he had included the thirty years before 1874 he would have found a period of steady increase. In England alone the birth-rate from 1838—1841 was 31.97 per 1,000 population. (a) For the United Kingdom I have not been able to obtain the exact average rate, but it would be somewhere roughly about 30. So that the birth-rate of 1900 has practically reverted to that of 1840. During the sixty years that intervened there was a steady increase for nearly thirty years to a maximum (36.3 in 1876), and then a steady fall for

(a) "Fifth Annual Report of Registrar-General in England, 1843."



thirty years to a minimum and somewhat lower figure than that of 1840. Dr. Taylor says the fall is due to artificial prevention of conception, which he carefully states is a new condition introduced within the last thirty-five years. To what does he attribute the increase? Why, again, does the birth-rate of 1840, before artificial prevention was in vogue, stand practically at the same figure as that of 1900? Clearly, by his own account, prevention had nothing to do with the average birth-rate of 30 in the year 1840. It is just as necessary for Dr. Taylor to find an explanation for the figures of 1840 as those of 1900. The figures that he would have us believe are of such terrific import in 1900 must surely have had their significance in 1840.

Is it not possible that the birth-rate has waxed and waned during the latter half of the nineteenth century in obedience to economic laws? We know, for instance, that the marriage-rate varies exactly with the activity of trade, and the number of births has a close relationship with the general prosperity. We know, moreover, that as the result of free trade, the last century witnessed a vast increase in the national wealth, as well as its more equal distribution in the shape of wages and income. May not the increase and decrease of the birth-rate be regarded as a delicate index of the general prosperity, not only as regards the actual amount of wealth in the country, but as to its just and equitable distribution? The decline in the birth-rate of 1900 may possibly point to an approaching limit of population under present social conditions.

The facts of the case may be conveniently illustrated by taking the particular instance of the Borough of Islington, with an estimated population for 1903 of 339,197 persons. The picture reproduces in miniature the main features of the national birth-rate, and has been carefully dealt with by the able medical officer of health, Dr. Alfred E. Harris. The later marriage age of woman is shown in the following table:— (a)

TABLE VI.

SHOWING THE PROPORTION OF MARRIED WOMEN AT FOUR PERIODS OF THEIR CHILD-BEARING AGES, IN EVERY 1,000 OF SUCH MARRIED WOMEN.

Age Periods.	Census Years.		Increase or Decrease.
	1891.	1901.	
15—20 .. ..	8.14	6.36	— 1.78
20—25 .. ..	133.05	124.69	— 8.36
25—35 .. ..	468.94	481.99	+ 13.05
35—45 .. ..	389.87	386.96	— 2.91

The next table brings out clearly the fact that although the number of women capable of bearing children had largely increased, yet the number of children borne by them had largely decreased. So far as the births among unmarried women are concerned, a decrease of 20.2 per cent. in the birth-rate is recorded.

TABLE VII.

	1,000.00		Increase or Decrease.
	1889-93.	1899-'03.	
Average number of unmarried women and widows at child-bearing ages .. ..	45.032	47.711	+ 2,689
Average number of married women at child-bearing ages .. ..	39.152	42.598	+ 3,446
Births per 1,000 unmarried women and widows at child-bearing ages .. ..	6.61	5.28	— 1.33
Births per 1,000 married women at child-bearing ages .. ..	237.6	211.3	— 26.3
Number of births among unmarried women and widows at child-bearing ages .. ..	1,488	1,258	— 230
Number of births among married women at child-bearing ages .. ..	46,524	45,015	— 1,509

(a) "48th Annual Report of the Borough of Islington," 1904.

The illegitimate births registered in Islington between 1851 and 1900 were in ten-yearly periods:—

TABLE VIII.

Periods.	Illegitimate Births.
1851—1860	1,335
1861—1870	2,651
1871—1880	2,429
1881—1890	3,475
1891—1900	2,710

The birth-rates of Islington from 1841 to 1903 were:—

TABLE IX.

Periods.	Birth-rate.
1841—1850	28.65
1851—1860	34.54
1861—1870	37.20
1871—1880	36.60
1881—1890	32.56
1891—1900	29.11
1901	27.62
1902	26.80
1903	26.48

During the sixty years covered by the ten-yearly periods, the birth-rate rose to a maximum about its middle, while the figures at the beginning and the end nearly coincide.

Dr. Taylor advances no facts in support of his assertion that artificial prevention of conception is the main cause of the decline in the birth-rate. Most medical men receive the confidence of patients in sexual matters, and they would probably admit that such practices are increasingly prevalent among the better-off classes of the United Kingdom. They would probably agree, also, in questioning prevention as the main cause of the falling birth-rate, principally on account of the futile character of the means employed. Such methods are usually adopted by those in whom continence is not a virtue, and breakdowns in the arrangements occur often enough to nullify the gross effect of most of the precautions. On the contrary, how often does one meet with the opposite state of mind—a desire for children which Nature denies? Admit that artificial prevention is increasing among the wealthier classes, Dr. Taylor would have to prove, in order to maintain his position, that a corresponding decrease in the birth-rate has not affected the birth-rate of the poorer classes. He had made no attempt—not even by the royal road of assertion—to show that artificial prevention is practised to any extent among the poor.

(To be concluded.)

## A CRITICISM OF THE MOSQUITO THEORY OF INFECTION

### IN MALARIA AND YELLOW FEVER.

By DR. L. CHEINISSE,

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

To raise the question of the importance of the mosquito in respect of the infection of malaria and yellow fever will no doubt savour of audacity to many, but I propose to do so in deference to Montaigne's maxim that "when a new doctrine is put forward we have every reason to look askance at it." Indeed, it is impossible not to feel a lurking scepticism in view of the enthusiasm with which this novel theory has been everywhere accepted. When, some fifty years ago, J. C. Nott promulgated the theory that mosquitoes were instrumental in conveying the infection of yellow fever, he little thought that one day his hypothesis would become the *credo* of epidemiology, not only in respect of *vomito negro*, but of other infective diseases. *Habent sibi fata*. Suspected by Nott and elaborated by Finlay, the theory of the transmission of yellow fever by mosquitoes elicited no echo, and it had fallen into oblivion when the researches of certain English and Italian observers on the rôle of the mosquito in

propagating malaria directed attention to this factor of contagion. "The mosquito," writes M. Bard, "introduced into the domain of pathology by the filaria, soon aspired to a wider field of usefulness, and at present yellow fever is in part its work, while malarial fever is its predilection." But this writer is too modest in describing the rôle of the mosquito in yellow fever as "partly" accounting for infection. Things have reached such a pass that it is impossible to conceive the contagious character of *typhus amaril* without invoking the assistance of the *Stygomyia fasciata*. According to present views quarantine is unnecessary, nay, even a person suffering from the disease cannot transmit it in the absence of the mosquito link of the chain. The American Cuban Commission is equally emphatic on this point, so that the prophylaxis of yellow fever is reduced to the simple aphorism: *Vitandi culices, delendi culices*.

In support of this view we are referred specially to the observations of American pathologists on the inoculation of yellow fever by mosquitoes. Apart from the fact that these observations are open to criticism it is worthy of note that they leave the exact nature of the poison a matter of doubt. The parasites of the *Stygomyia fasciata* comprise fungi, ferments and sporozoa, but none of these has any bearing on yellow fever.

The etiological similarity between malaria and yellow fever, so often invoked in favour of current views, obviously falls to the ground. For the analogy to be complete it would be necessary to admit, in regard to yellow fever, the existence of a specific hæmatozoön which, like that of malaria, has its evolution in two different hosts. As M. Bandi remarks, it would be strange if this problematic hæmatozoön could pass one phase of its existence in the organism of an insect without the latter exhibiting the slightest trace of this cellular parasite. From this point of view the mosquito theory, as applied to malaria, is much more satisfactory. The description of an invisible germ ingested with contaminated blood, which for twelve days undergoes some obscure change in the body of the *Stygomyia*, hardly commands acceptance. Moreover, it is especially by analogy that the theory of the transmission by mosquitoes has been extended to yellow fever. The moment is opportune to ask ourselves to what extent this theory falls into line with the facts even in respect of malaria, a question that has been infinitely better studied than the problem of *typhus amaril*.

The transmission to man of the malarial poison by the anopheles is, we must admit, based on a considerable number of duly observed facts. The infective rôle of this insect has been experimentally established, and the life history of Laveran's hæmatozoön, with its two phases, the asexual reproduction in the human blood and the sexual generation inside the body of the mosquito, is well known. But does that justify the assumption that the infection of the human being by the insect and that of the insect by man constitute the complete cycle? In other words, is the mosquito bite an indispensable formality before man can become infected with malaria? Can we really affirm that in the absence of the mosquito there is no risk of contracting malaria?

I do not propose to discuss *seriatim* all the arguments that have been brought forward in support of the mosquito theory, especially as many of them have already been refuted. (a) Moreover, their importance varies greatly, many of them having been advanced merely to bolster up the theory, and, therefore, do not deserve attention. It is obviously impossible to admit that the comparative immunity of the aborigines of hot climates is due to the thickness of their skins and to the pronounced odour which scares away the mosquito, since filariasis—also transmitted by culicidæ—is commoner among the black than among the white population.

(a) See "La Théorie des Moustiques est-elle Univoque?" *Navarre. Lyon Med.*, November, 1900.

Instead of discussing at length arguments of this class, I prefer to bring together a certain number of facts which, far from confirming the rôle of the anopheles as the sole agent of transmission of malaria, tend rather to throw doubt upon the existence of any constant relationship between any kind of mosquito and malarial infection.

First of all the geographical distribution of the anopheles by no means corresponds to the distribution of malaria. This insect abounds in certain regions whence malaria has quite disappeared, or has never existed. It may be objected that the most important fact to take into consideration is the numerical distribution of the insects in question. But even from this point of view the theory fails, for, according to Dr. Sargent, they are far more numerous on the banks of the Essonne, where malaria is almost unknown, than in certain admittedly malarial districts near Algiers. Dr. Sargent is therefore obliged to explain the disappearance of malaria on the banks of the Essonne by invoking other factors—drainage, &c. In any case, it is obvious that there is no sort of parallelism between the presence and number of anopheles and the existence of malaria. We shall be told, of course, that the anopheles is only dangerous as a vehicle for the transmission of the virus, and that in the absence of infected subjects the insect is harmless. But, apart from the fact that this does not explain the disappearance of malaria from districts once infected where the anopheles continues to abound, the theory is one which M. Celli himself admits is not without exceptions, since he mentions districts where, though malaria is rife and the anopheles numerous, new-comers are not infected. M. de Francesco, on the other hand, points to districts deeply infested with malaria where no anopheles has been seen. He consequently protests against the dogmatism which declares this insect to be the sole agent in the propagation of malaria. If the anopheles can do this thing, why not the *Culex pipiens*? It is true that he did not succeed in discovering in the intestines and salivary glands of the latter the ovoid and the spermoid of the hæmatozoön, nor the zygotes which is the outcome of their conjunction, but is it not well known to be unnecessary for the hæmatozoön of malaria to traverse the body of another being to be enabled to convey the poison of malaria?

It is not enough, indeed, to admit that the anopheles has no monopoly in this respect as the partisans of the theory would have us believe. The truth is that malaria can be propagated without the intervention of a mosquito of any sort. Epidemics of the kind have already been described, as, for instance, after heavy rains (Canton of Lourmel, Algeria). Dr. Gros remarks, in reference to this outbreak, that he had done his best to discover some specimens of anopheles, but had utterly failed, although the local conditions were distinctly favourable to their development. Mosquito bites may certainly serve as the front-door for the entrance of the malarial poison, but there are certainly other means of penetration. Even if an insect of some kind be regarded as indispensable to the transmission, it is not necessarily or always the anopheles.

I will now adduce some epidemiological observations more to the point. Taking the sanitary returns of the Prussian army, Dr. Grawitz made graphic records of the prevalence of malaria in the 1st and 4th Corps, the regiments most subject thereto. Now malarial infection is very general from the onset of spring, that is to say, at a season when, in Eastern Prussia and Posen, mosquito bites must be extremely rare. On the other hand, during July and August the incidence of the disease falls quite suddenly, although the men are at that time most discomforted by mosquito bites.

Dr. Muller, a Russian army medical officer, has studied the co-relationship of mosquito bites and malaria for three years in Bessarabia, a region where malaria is endemic. In the three years in question

the proportion per thousand of men attacked by malaria was as follows:—

	1899.	1900.	1901.
May .. ..	3'78	4'45	3'93
June .. ..	5'90	2'91	5'81
July .. ..	3'24	4'81	9'80
August.. ..	3'44	7'56	11'22

With respect to the mosquitoes, he states that they were altogether wanting in 1899, while in 1900 they abounded in these districts; in 1901 there were but few, and they almost disappeared in August, which happened to be cold. More than this, in June, 1900, the proportion of soldiers infected was only one-half that in 1899. Lastly, during the third year, when mosquitoes were rare, the sickness remained at about the same figure as in 1899 for the first two months, then, in July, without any perceptible increase in the number of mosquitoes, it increased considerably, and in the following month, at a time when the mosquitoes had disappeared altogether, the percentage reached a height never before attained. In short, apart from the month of May, the malarial sickness during 1901 was throughout twice as great as the previous year, which was particularly rich in mosquitoes.

It would be difficult to allege a more flagrant discrepancy between the presence of mosquitoes and the prevalence of malaria. If, on the other hand, we bear in mind the other factors, such as temperature, atmospheric moisture, the rainfall, &c., it is seen that the oscillations recorded on the charts correspond to these meteorological or telluric influences.

Dr. Kourlov's observation at Tomsk, in Siberia, are not less conclusive. Malarial infection usually commences to make itself felt in March, at a time when the earth is still covered with snow, and the thermometer marks about 10° C. below zero, conditions hardly favourable to the existence of mosquitoes. It attains its maximum in April, yet there was on an average twenty-seven days under freezing point, and the average temperature was 1.2° C. below zero. According to Dr. Vender, who carried out his observations in another Siberian town, Kolyvan, malaria commences, as at Tomsk, in March, and since the disease is propagated during March and April without the intervention of the mosquito, we are entitled to ask whether these really play such an active part in its dissemination.

However this may be, it is evident that the mosquito cannot be regarded as the sole agent of the transmission of the disease. This being so, it becomes us to exhibit a certain reserve before accepting the triumphant narratives of protection against malaria by gauze shutters. Although the very antiquity of the telluric theory is against it, we need not fear to hold, with Dr. Bard, that the improvement is to be attributed rather to improvements in the soil than to the destruction of the larvæ of mosquitoes.

If this be the case in respect of malaria the greater must be our reserve when it is sought to extend the theory to yellow fever. It is purely a case of reasoning by analogy; indeed, we are asked to believe in "the presence of hæmatozoa, as in malaria, which, moreover, offers the closest resemblance to yellow fever." These hypothetical hæmatozoa of yellow fever cannot for the time being be otherwise described than as presenting a certain resemblance with the "animalculæ" described by Athanasius Kircher and von Leeuwenhoek as being at the root of all epidemic maladies. It really seems as if, in the words of an eminent English observer, "the reign of the bacteria has attained its apogee, and that of the hæmatozoa is now about to begin."

No doubt the results of experimental inoculations of yellow fever by mosquitoes are extremely suggestive, but as Dr. Berenger-Feraud points out, the disease thus inoculated may not improbably be inflammatory bilious fever, i.e., a relatively mild form of yellow fever. This view is endorsed by Dr. Mendonça, who feels certain that the disease observed by Finlay and by American observers at Cuba and Sao Paulo was, in reality, the inflammatory fever of the Antilles. The only really characteristic experiments are those

carried out by Dr. Guiteras at the Havana Hospital, in which the typical symptoms were present, and the diagnosis was verified post-mortem. But, unfortunately for their conclusions, it is precisely the experiments carried out at Havana that gave positive results, while those of Reed, Carroll, and Agramonte failed to demonstrate the truth of the new hypothesis.

Without discussing in detail the conclusions of the American Cuban Commission, I submit that we can in no wise attribute the disappearance of yellow fever at Havana to measures taken for the destruction of mosquitoes. Dr. Souchon, basing his conclusions on the statistics of yellow fever since 1817, points out that the disease usually wears itself out in from two to four years, unless revived by fresh cases imported from outside, whence it follows that quarantine and the disinfection of merchandise are necessary measures. Moreover, Dr. Souchon states that the number of mosquitoes has not apparently diminished in Havana. Dr. Andrade reports several instances of places in Brazil where the authorities succeeded in stamping out yellow fever before the mosquito theory had been invented. On the other hand, the destruction of mosquitoes at Sao Paulo and neighbouring localities does not, so far, appear to have had any influence on the prevalence of the disease.

In 1901 Dr. Purnell published a series of observations on the transmission of yellow fever by infected fomites, and he points out that the lapse of time between the original cases and the subsequent infection was too great to allow it to be possible to incriminate the mosquito. He himself attributes but trifling importance to the part played by the mosquito in the dissemination of yellow fever. The history of the great epidemic at Grand Bassam in 1902 is specially conclusive from this point of view. This place had on several occasions witnessed outbreaks of the disease, and the last epidemic was in 1899, since which date no cases presented themselves, until, on July 19th and 20th, 1902, some well-marked cases occurred. In 1899 cases had occurred in pretty well all the houses of Bassam, and in one house five out of six died. Near this house was a pool of brackish water into which the dejections and soiled effects of the victims were thrown in 1899. The medical authorities had long demanded the filling in of this pool, and in July, 1902, steps were taken with this object in view. Now, all the persons attacked by yellow fever in 1902 lived in the neighbourhood of this pool, or had close relations with those who did. It follows that contaminated objects are capable of transmitting the disease, even after three years—that is to say, long after the infected mosquitoes must have perished, even if we credit them with extraordinary longevity.

Before deciding that the prophylactic measures hitherto enforced are absurd, it behoves us to think twice, for at present it seems a bold thing to contend that the whole prophylaxis of yellow fever consists "in preventing the *Stygomysia fasciata* from biting the healthy after biting the sick."

## THE CRIMINAL RESPONSIBILITY OF THE ALCOHOLIC. (a)

By WILLIAM C. SULLIVAN, M.D.,  
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THE author made allusion to the fact that the legal responsibility of the alcoholic had already been the subject of discussion by the Society, and in this connection the names of Dr. Crothers and of Dr. Norman Kerr were specially to be remembered.

He remarked that when we speak of alcoholic

(a) Abstract of a Paper read before the Society for the Study of Inebriety, at the Rooms of the Medical Society of London, Tuesday, July 12th, 1904.

crime we generally have in mind homicidal offences, for, though alcohol leads to other forms of delinquency, it is in murder that its influence is most evident; in this country, at all events, it is the most important individual cause of that crime. In discussing legal responsibility, it will be practically convenient to adopt the same attitude, and to limit our observations to cases of homicide.

In such cases the question of responsibility arises in connection with three conditions:—(i) Chronic alcoholic insanity; (ii) delirium tremens; and (iii) the dreamy mental state of morbid drunkenness.

In the first-named condition the question is decided by the same criteria that are admitted in non-alcoholic insanity, so that its consideration need not detain us. Similarly, cases of distinct delirium tremens present no special difficulty. It is when we come to cases of alcoholic automatism, to crimes committed in the dream states of pathological drunkenness, that we meet with differences in opinion and practice, the condition being sometimes held of no account, sometimes admitted as an extenuating circumstance, and sometimes treated as equivalent to legal insanity. On this account, and because these cases constitute the large majority of alcoholic crimes, it is desirable to devote special attention to them, and they are accordingly suggested as the special subject of this discussion.

The objection to recognising alcoholic automatism as a morbid condition modifying legal responsibility appears to rest chiefly on the fear that there would be therein some risk of abuse; any criminal, it is said, would only need to get drunk in order to secure immunity from his misdeeds. Those who entertain this fear, however, do not take account of the fact that the automatism of the alcoholic is really a very definite condition as to its character and as to its causation. Of course, an element of automatism belongs even to the common phenomena of drunkenness, but it is only when the symptom has become very much exaggerated in degree that we have the dream states here considered, with their tendencies to criminal conduct. *And this exaggeration occurs only in neuropathic subjects.* Most commonly this neuropathic predisposition is due to chronic alcoholism; what ordinarily happens, in fact, is this—after many years of intoxication marked by symptoms of common drunkenness, the individual acquires a peculiar susceptibility to alcohol, so that relatively small doses lead to more or less lengthy dream-states, in which the patient may seem to speak and act pretty coherently, though in reality he is in a sort of somnambulistic state and knows nothing at all afterwards of what he has done, or has only a hazy recollection of it; in one of these phases he will probably murder his family, or attempt suicide. Besides chronic intoxication, which is the most frequent cause, other conditions also predispose to automatism under alcohol, and of these epilepsy, head injury, and insane hereditary taint are the most important.

It is this constant relation to a definite neuropathic disposition that is the most distinctive and important fact about alcoholic automatism, and the recognition of this fact should go far to dispose of the fear that the admission of irresponsibility in such cases would lead to abuse. No

one becomes mad when drunk who is wholly sane when sober.

Regarding the condition of memory in these cases, it is to be noted that the amnesia is often incomplete, and also that its development may be delayed, so that there may be a clearer recollection of the crime immediately after the dream phase than at a later period.

In connection with the general demeanour of the automatic drunkard, much interest attaches to a recent observation of von Gudden, who has found that in about half the cases of this condition with irritability of temper, there is impairment of the light reflex, lasting as long as the dreamy state persists. This may possibly prove a valuable medico-legal test.

The admission of morbid drunkenness as a condition excluding full responsibility is especially desirable in that it would further the trend of public opinion to adopt preventive measures against the criminal alcoholic. It is, in fact, mainly as a means of eliminating potential criminals that the institutional treatment of ordinary drunkards is of use to the community. When, therefore, the chronic alcoholic has once shown the disposition to dream states with impulsive tendencies, especially homicidal or suicidal, he ought to be dealt with on the same footing as the impulsive epileptic—immune from ordinary punishment, but unfit for ordinary freedom.

## THE VESTIGES OF SYPHILIS.

By FRANK H. BARENDT, M.D. Lond., F.R.C.S.,  
Senior Physician, St. George's Hospital for Diseases of the Skin;  
Consulting Dermatologist Royal Southern Hospital, Liverpool.

It frequently happens that the question of syphilis arises in connection with the disease from which the patient is suffering. As a correct answer is of supreme importance in treatment, it occurred to me that a short account of those imprints that may be left behind by the disease would be of general interest.

I need not allude at length to the numerous diseases which may arouse in our minds a suspicion of previous syphilis. It is well known that many anomalous nerve affections—eye, ear, nose, throat, and cutaneous troubles, &c.—often suggest syphilis as an etiological factor. It therefore behoves us to make use of all the knowledge of this far-reaching disease that we have in the excellent clinical observations that have been handed down to us by syphilographers of former days.

With regard to inherited syphilis, the Hutchinsonian triad is now universally accepted as an indication of congenital syphilis, and all of us recognise its value. The condition of all the permanent teeth is important, and a careful examination of the molars should not be omitted. These are often dome-shaped, due to the imperfect development of the cusps, and present consequently smaller grinding surfaces than normal. This condition of the molars has remained well marked in cases where the notches in the incisor teeth have lost their striking character through attrition.

Are there any signs, more or less permanent, upon which we can rely as evidence of syphilis which the patient may have acquired years ago? At the outset, we can ask the patient the leading question, to which we may get a correct answer; but the nature of the disease, the method of infection, the evanescent memory of early lapses from right conduct, all combine to render the:

patient prone to oblivion of such an event in his life, especially if unmarked by his having had to seek medical advice. Even when an unwilling admission is extracted, it frequently happens that he glosses it over with a smoothness that makes his cross-examiner wonder whether his suspicions are not after all ill-founded; and that, in his desire to clutch at some definite cause, he may wrongly appraise the diagnostic value of the statements of his patient.

Far be it from me to malign any special calling, but I cannot help thinking that if the patient is, or has been, a sailor or soldier, or one whose business takes him frequently from home, these occupations bring greater liability to the infection of syphilis than any other in this country. Another point I should lay stress upon is the abuse of alcohol in the early adult life, for there is no doubt that syphilis has often been acquired when the control of the higher senses is impaired.

As regards the nature of the initial lesion, I venture to think that too much value is attached to the absence of a sore, be it soft or hard, on the penis, and too little to the history of what our patients call a "simple running." It is a matter of common knowledge that the famous John Hunter, from an experiment on his own body, largely retarded our progress by confounding syphilis and gonorrhoea, and ascribing them to the same contagium. His error has been explained by the supposition that he inoculated himself with the discharge from a urethral chancre, and that the discharge mistaken by him for gonorrhoea was due to the concealed chancre. I have carefully read the history of this famous experiment, and feel that such an acute observer as he undoubtedly was could scarcely have overlooked the presence of a urethral chancre. I venture to suggest that the disease with which he inoculated himself was actually syphilitic urethritis. That syphilis may produce urethritis is admitted by all competent recent syphilologists, and, like syphilitic colitis, is due to the presence of syphilides in the mucosa. We admit the infectivity of mucous patches in the mouth and throat, and therefore the simple running, as the phrase goes, taken together with the anomalous disease the patient at the time of our examination presents, may turn out to have been a true syphilitic urethritis, and represent the primary stage of infection. At any rate we must not exclude all possibility of syphilis because there is no history of sore or of skin troubles, and only one of simple running.

*Syphilis d'emblee* of French syphilographers, where the initial effect is not demonstrable, can thus be explained, the site of the initial infection being intra-urethral, of the nature of a mucous patch, and unnoticed by the patient. The same holds good for balanoposthitis, for it is well known that the desquamating papule—one type of the initial sore of syphilis—may be masked by a profuse secretion due to balanitis and posthitis. Extra-genital infection should not be forgotten; and although infrequent in this country, suspicious depressed stellate scars, in the absence of a satisfactory history of trauma, should put us on our guard. Digital infection is by no means so rare as is generally supposed, and is not only confined to medical men and midwives.

A few remarks may not be out of place with regard to secondary syphilis, *i.e.*, the presence of syphilides of the skin and mucosæ as far as these can be inspected during life. It is well known how

unobservant many patients are of skin eruptions, especially when they are not pronounced and unaccompanied by itching. We should remember that women infected by their husbands frequently never have and give no history of a secondary eruption, especially when pregnancy occurs about the time of infection. As far as my experience goes, I have seen secondary syphilis most frequently in women who are not and have never been pregnant; but in those who are parous and indubitably have contracted syphilis in their early married life, it has been rare to get a history of cutaneous and mucosal eruptions, although one of frequent abortions is common enough. In both sexes a history of piles should not make us forget the possibility of their being condylomata.

Of the vestiges left by antecedent syphilis, no one by itself is pathognomonic; and such as they are, they must be carefully weighed together with the nature and history of the disease for which the patient seeks our advice. One of the most important is a scar, depressed, irregularly marginate, and occupying a region of the body not liable to injury in ordinary pursuits, and where history of injury is excluded. If such scars are multiple the suspicion is strengthened; and if in addition there is a disturbance of pigmentation giving rise to map-like configuration, the explanation should be very satisfactory indeed from the patient if we are to abolish from our minds the idea of syphilis. The presence of a scar on the penis is of value; whether a soft sore produced it or a hard one has, or ought to have, little weight with us when we suspect syphilis. Far too much has been made of this character as a diagnostic criterion; and although most writers admit of the two types of sores, yet a soft sore may be the site of the inoculation of syphilis, just as a hard sore may be but a local ulceration due either to a specific bacillus (Ducrey) or to pus organisms. The multiplicity of a sore is no proof at all of its being simple in its nature; and when in Vienna I saw multiple hard chancres, two being on the left index finger, one on the corona, and two on the body of the penis. In my experience, whenever a patient admits having had a chancre, the scar can be discerned on careful examination of the site even when several years have elapsed since infection. Herpes preputialis may leave scars, especially after recurrent attacks, but here we have no loss of substance to the same extent that obtains in chancres.

Syphilis has been termed big-pox in contradistinction to variola or small-pox. Pustular syphilides are at present among the least frequent of secondary eruptions, and such is the experience of Continental observers. I myself have only seen one case where the secondary eruption was stated to be pustular, and at first glance I mistook the condition for a previous attack of small-pox. The pocks were deeper and whiter, and the immediate surrounding integument was much more pigmented, but the pitted face looked very like that produced by small-pox. There was, however, abundant evidence of the disease being syphilitic, quite apart from the patient's statement.

Scars in the sural and peroneal regions, although the legs are more liable to injury than other members, are always suspicious. On the front of the shins the evidence is of little value, for most of us have had some injury inflicted upon them at some time or another. Pigmentation in this region is frequently seen in women who have a penchant

for warming this part of their anatomy, and must not be wrongly interpreted. It constitutes the "ephelides ab igne" of authors, and when well developed may lead to mistakes in diagnosis.

Eruptions on the palms and soles are suggestive, especially when they take the form of discrete papules surrounded by a scaly ring, *papules en collerette*, as French dermatologists call them. In examining the skin, and especially the hands and feet, for such vestiges, the patient should be warm, otherwise the natural mottling of the skin—the so-called *cutis marmorata*—may interfere with our correct appreciation of such eruptions.

Leucoderma is an important change, and when present is a valuable sign of previous syphilis. It is due to circumscribed loss of normal pigment, whereby white spots are formed, surrounded by pigmented rings which shade off into the normal colour of the skin. Such spots of leucoderma may develop in the site of former efflorescences, be these early or late syphilides. They persist for a long time, are most often seen on the nape of and sides of neck, and are apparently more frequent among women than men. I can testify to the value of this important cutaneous change, and have frequently found it confirm the suspicion of syphilis. The affection may assume figured patches, and the marked pigmented border helps to distinguish it from leucoderma which may arise in the course of malignant disease. In all cases of suspected syphilis, I would urge the careful inspection of the neck, especially for white spots surrounded with pigment rings—standing out in marked contrast to the neighbouring skin. This can readily be done without drawing too much attention.

Generally speaking, syphilides are essentially pigment disturbers, and therefore any mottling or discoloration of the skin should be taken note of in determining the question of previous syphilis. Gentle pressure by a microscopic slide will expel the blood from the subjacent capillaries, and thus render the pigmentation more readily manifest.

White scars in the *rosa* of the lips are of great value, especially if these are at the angles of the mouth. The mucosa should be most carefully inspected, more particularly the inner surface of the cheeks; fine irregular and opalescent streaks are always suggestive and persist for a long time after other manifestations of syphilis have passed away. Any marked loss of submucous tissue causing depression of the mucosa is, in the absence of any history of traumatism, most suspicious.

Many authors lay stress on enlargement of nuchal glands as persisting long after cutaneous and mucosal syphilides have disappeared. In my experience I rarely have found such a condition, although it is common enough for these glands to share in the general adenopathy that accompanies the secondary period.

But there is one site in women where syphilides linger longest, and that is at the junction of the hairy scalp and nape of neck, just as in men in the temporal region. These areas should always be inspected for traces of syphilides. The long persistence of seborrhoeic eruptions should always suggest a possible syphilitic basis.

The eyes should always be examined for the Argyll-Robertson sign (loss of pupil reflex to light, with the power for accommodation unimpaired). This sign when present should always arouse a suspicion of previous syphilis being the cause, even when no other nerve lesion is manifest.

I believe that these vestiges constitute irrefutable proof of acquired syphilis, and should ever be present in the mind of the examiner when this question arises. I have endeavoured to guard myself from being too dogmatic, and I repeat that there is not one of these points taken by itself that may not be capable of another interpretation. On the other hand, when we meet with two or more—e.g., scars and pigmented areas with no history of trauma, I think we are perfectly justified in placing a patient who is suffering from some disease of which the etiology is veiled, tentatively at least, on antisiphilitic treatment.

## Clinical Records.

### A SERIES OF CASES OF PUERPERAL INFECTION TREATED BY THE INTRA-UTERINE APPLICATION OF IODISED GAUZE.

Under the Care of E. CABANES, M.D.,  
Chef de Clinique at the School of Medicine of Algiers.

For some time past I have treated every case of puerperal infection that has come under my care by a novel procedure which has yielded such uniformly satisfactory results that the notes of some of the more recent cases may not be without interest. Briefly described, the treatment comprises the removal of any fragments of placenta or membranes, by the aid of the blunt curette if necessary, followed by irrigation with an antiseptic solution. The next step is to introduce into the uterine cavity a strip of gauze steeped in an aqueous solution of iodine and iodide of potassium, 4 per cent. of each. The strip is only loosely packed, and when the cavity has been filled a vaginal douche is given and a plug of iodoform gauze placed in contact with the cervix to absorb any leakage of iodine, thus avoiding injury to the vagina. The dressing may advantageously be renewed every twelve hours so long as there is the slightest rise of temperature, but marked benefit usually follows the very first dressing. The treatment, moreover, is applicable as well to recent cases as to cases of old standing. The presence of peri-uterine inflammation is no bar to its performance; indeed, it is indicated in all cases of uterine infection, at all stages and under all conditions.

**CASE I. Puerperal Septicæmia of twenty days' standing.**—Madame S., multipara, became feverish soon after delivery of a child at term. Eight days later (January 5th) medical advice was obtained, and the uterus was washed out twice daily with boiled water, in spite of which the temperature continued to oscillate between 99° and 103.8° F. Irrigations with sublimate solution were then substituted, but the disease continued to run its course unchecked, and the patient fell into a state of intense prostration, with severe rigors and exhausting sweats. On the 15th, her temperature was 104° F., and the pulse 150 per minute. Her condition was alarming in the extreme. The first iodised dressing was then introduced, and on the following day the temperature was almost normal. The dressings, however, were renewed twice daily, and by the 18th the temperature had returned to normal, the pulse being 96. This case is noteworthy in that the dressing gave an immediate result, although the infection was of twenty days' standing. Nine dressings were applied in all before the temperature finally returned to normal.

**CASE II. Puerperal Septicæmia.**—Madame O., primipara, was delivered of twins on February 5th, having been attended by the same midwife as the patient in the preceding case. In the meantime, this midwife had infected several other parturients, two of whom succumbed to the disease. Things went on all right for the first ten days, when the patient was seized with fever, and her pulse rose to 24 per minute. On the 16th the temperature rose to 105° F., and she had severe rigors. The vulva and cervix were covered with a diphtheroid exudation, and there was a discharge of pus from the os uteri. After the application of the



iodised dressing the temperature fell to 99° F. and the pulse to 100. On the 17th, it rose again, but after two more dressings it fell permanently to normal. After the 19th only antiseptic injections were employed.

CASE III.—Miss X., primipara, was confined on March 12th. Her temperature became irregular on the 19th, and Dr. Vincent was called in consultation. On the 20th, although her temperature was only 99° F., the pulse was 120, and she had just had two severe rigors. There was a rather extensive laceration of the cervix, and the lochia were somewhat offensive. Blood-stained pus could be seen escaping from the os uteri. The patient was curetted and in the course of the ensuing twenty-four hours two iodised dressings were introduced. An hour after the curettage she had another violent rigor, during which the pulse-rate rose to 130 per minute; but on the 20th, after a third dressing, the temperature fell to and remained normal. The patient was discharged cured a fortnight after the onset of the illness.

CASE IV.—Miss P., the subject of syphilis, had aborted for the third time as the result of an illegal operation at two and a half months. She had been ill for a week, but as her temperature continued to rise she reluctantly called in a doctor. She was evidently gravely infected, and the vaginal discharge was intensely foetid. She was admitted to hospital, where the uterus was immediately curetted and the iodised dressing applied. The temperature was only 99°, but she developed symptoms of pelvi-peritonitis, which continued to run its course, although on the third day all disagreeable odour had disappeared from the vaginal discharge. She ultimately developed pyosalpinx, which gradually and slowly became encysted, the uterus remaining embedded in a mass of fibrous adhesions. The constitutional infection found expression in a pulmonary infarct and a metastatic abscess in the right rectus abdominis muscle, in spite of which she recovered. One is fain to ask what her fate would have been if the uterus had not been thoroughly aseptically. This case is particularly interesting in that it proves the utility of the treatment even in cases in which the infection has extended beyond the limits of the uterus. Although the dressing does not, of course, hinder the evolution of the peri-uterine complications, it at any rate removes the original, and also the central, focus of infection, and in so doing it must unquestionably tend to modify the course of the collateral infective manifestations.

*Conclusions.*—The results obtained in every case of puerperal infection which has come under my observation since I began this treatment appear to me to justify the following conclusions, viz., (1) that the iodised dressing can be applied repeatedly without the slightest risk to the infected uterus; (2) it should be applied every twelve hours in order to make sure of obtaining prompt and certain effects; (3) its repeated application cuts short the attack of puerperal endometritis within a few hours; (4) it may determine recovery even in advanced cases; and (5) it is also applicable to cases of generalised septicæmia, although complicated by peritonitis, in that it removes the central focus of infection, although in such cases its curative influence is necessarily reduced.

### Transactions of Societies.

#### NORTH-EAST LONDON CLINICAL SOCIETY.

The annual meeting of this Society was held at the Tottenham Hospital, N., on Thursday, July 7th, 1904, the President, Dr. J. W. HUNT, being in the Chair. The Council's Report for the last session showed that much good work had been done, many valuable communications having been made in the shape of papers, while the Clinical Cases and pathological specimens exhibited at the meetings had been both abundant and of more than usual interest.

The report having been adopted, the ballot for officers for the ensuing session then took place with the following result:—*President*, Dr. R. Murray Leslie. *Hon.*

*Treasurer*, Dr. A. E. Giles. *Hon. Librarian*, Dr. A. J. Whiting. *Hon. Secretaries*, Messrs. H. W. Carson and C. E. Hutt. The Vice-Presidents and Council were also elected in accordance with the recommendation of the Council.

The meeting then resolved itself into a garden-party held in the beautiful and picturesque grounds of the hospital (by kind permission of the Board), and which was well attended by members and their friends.

### British Health Resorts.—I.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

#### SIDMOUTH.

SIDMOUTH forms an ideal south-country resort. It is situated in East Devon between the Rivers Exe and Axe, in the well-wooded Vale of Sid. Early in the nineteenth century it had gained a position as a desirable health station, and although of recent years it has been overshadowed by the rapid growth of other western resorts, it now bids fair to gain distinction among the places offering special attractions to the invalid and the health-seeker. The town, quiet and picturesque, and free from the barbarities of the modern, tripper-frequented watering-place, lies wedge-shaped in a horse-shoe valley. While open on the south to the sea it is protected on the west and east by red sandstone cliffs, which form the seaward limits of the protecting, wooded and green-pastured hills. The town is thus shielded from the winds most trying to the invalid, and yet so placed as to allow of the maximum exposure to the sun. The soil is dry and porous. The natural vegetation of the place is abundant, and well attests the mildness of the climatic conditions and richness of the land. The grassy, tree-covered slopes, and the richly wooded and high-hedged lanes, secure ample shelter and protection for the invalid. The hillsides and sloping valley form admirable ground for the carrying out of graduated exercise, while the pleasing, old-fashioned sea front provides a fair extent of level ground for bath-chair cases and those needing a restful exposure in the open. For the active, there are the Salcombe and Peak cliffs close at hand, the breeze-blown tops of which may be gained by a not too steep ascent of about 500 feet. On these airy uplands there is ample opportunity for vigorous exercise amidst picturesque surroundings, and with far-reaching views of sea-coast and undulating inland country.

Sidmouth enjoys much sunlight. In winter, there is said to be more sunshine than in most of our other south coast resorts; while in summer it is claimed that there is considerable protection from excessive glare. As regards the temperature, Sidmouth is warm in winter and not unduly hot in summer. The average of the winter minima is nearly two degrees above that of London, and the average of the winter maxima 17° above that of the metropolis. During 1903, the mean temperature of the year was 50.1°, and the average mean of the last thirty-two years, 49.61°. The mean daily range was for the last twenty-four years 8.6°. It is interesting here to note that during the great summer heat of 1899, the mean temperature of the month of August at Sidmouth was 63.3° (the highest register during the previous thirty years), and, notwithstanding this, it was from ten to twenty degrees cooler than London, and five degrees below that of any other health resort on the south coast during the greater part of the month. Sidmouth may rightly claim to possess a peculiarly equable climate, cool in summer and mild in winter. The absence of sudden change of temperature goes far to make the place a particularly suitable residence for convalescents, invalids, delicate children, adults of feeble constitution, and the aged. It may be here added that frost and snow are almost unknown, and fog is rare. Thunderstorms are also infrequent.

Devonshire is generally recognised as a rainy county, but at Sidmouth the rainfall is comparatively low, and is said to be 36 per cent. below that of the rest of the

county. This is doubtless due to the fact that the surrounding hills waylay the rain-laden clouds, while the high ground of Dartmoor precipitates much of the moisture brought by the west winds from the Atlantic. The rainfall for 1903 was 36.39 inches, which is 5.77 inches above the last twenty years' average (30.62 inches). The relative humidity is returned at 83, and well indicates the prevalence of desirable conditions for the invalid. As already indicated, the natural position of the town affords admirable protection from winds most trying to the feeble. The funnel-like form of the Vale of Sid doubtless in part accounts for the prevalence of invigorating breezes, which fortunately free Sidmouth from the relaxing and enervating characters of certain of our well-known southern resorts.

While Nature has been kind, man, in his control of the district, has been wise. There are no artificial attractions offered to the mere frivolous visitor. The sea-front is spoiled by no pier or unsightly pavilion, and even the railway station lies a good mile inland. If Sidmouth is to continue to grow in favour with both physician and patient, it will be well that its natural simplicity be preserved. Excellent accommodation is provided in several well-appointed hotels. Particular mention should be made of the new Victoria Hotel, situated within sight and sound of the sea, and yet surrounded by trees, at the western end of the front. The hotel has been excellently designed, and is perfect, not only in hygienic equipment but in all that makes for comfort and even luxury. Certain suites have been so arranged as to allow of an open-air treatment of any invalid residents. The number of private apartments in the town is limited. Sidmouth is also provided with well-designed baths, where Aix and Nauheim treatments, in addition to the usual complement of sea and fresh-water baths, are carried out, under the conduct of an experienced manager, as we have had personal opportunities of ascertaining. Adjoining the baths is a well-conducted club, open to visitors.

On the hillside, at the western end of the town, are attractive golf links. The hill slopes in the immediate neighbourhood of the town should prove peculiarly attractive to those of delicate health desiring a permanent country and sea coast residence. There is a fairly good drainage system, and the water supply is of exceptional quality and non-irritating to the skin. The town is clean and well lit. For the robust there are ample facilities for sea-bathing and the shore is safe for children. Sidmouth is a perfect resort for the convalescent, the chronic invalid, and the aged and all requiring the benefits of a "rest cure," and such climatic conditions as are associated with an equable and not too relaxing marine residence.

Catarrhal and cardiac forms of asthma are said to do well at Sidmouth. The baths offer means for the trustworthy treatment of judiciously-selected cardiac and rheumatic cases. Certain forms of neurasthenia should also gain much benefit, and for the recreation of the over-worked brain labourer and the rejuvenescence of the jaded victim of society, Sidmouth has much to offer.

A well-illustrated official guide has been published under the auspices of the Sidmouth Urban District Council, and interesting booklets have been issued concerning the baths. The excellent health reports of Dr. Pullin, the Medical Officer of Health, may also be studied with advantage. Sidmouth is 167 miles from London on the L.S.W. Railway, and may be easily reached from Waterloo Station in about four and a half hours.

## Continental Health Resorts.

[FROM OUR SPECIAL CORRESPONDENT.]

### AIX-LA-CHAPELLE (AACHEN).

THE celebrated hot-springs here are regaining, slowly, perhaps, but steadily, some of their former pre-eminence among German mineral-water resorts. The

vigorous advertising of some of the newer spas has gained for them fame in recent years; and, comparatively, the number of annual visitors to the older Continental health-stations has not increased proportionally to the respective merits of the waters. Aachen, however, can yet challenge comparison for its highly valuable springs, the elegance of its accommodation, and its city conveniences with any of its more energetic and youthful competitors.

In selecting a place of sojourn for a "cure" continuing several weeks, the advantages of a town residence merit attention. As a city of over 126,000 inhabitants, Aix-la-Chapelle has these; and, added to them, many local and antiquarian attractions. Its hotels, pensions, and apartment-houses are numerous and at all prices. Amongst them, the Hôtel Grand Monarque is deservedly popular with British and Americans for its up-to-date comforts, good table, and attendance.

The mineral springs are numerous, both in the town and the vicinity, and are used for drinking as well as external applications. They are prescribed for a variety of diseases, especially for gout, strictures, and rheumatism.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 16th, 1904.

### BACKACHE.

BACKACHE, says Dr. Fiessinger, belongs to divers affections. It is a symptom of very unequal value, as it is met with in the most benign as well as in the gravest maladies. It is for the practitioner to discover the nature of the pain. A patient comes to consult him for a pain in the back and asks to be relieved, and how will he set about it?

The principal seats of the pain are two—the dorsal and the lumbar region. In the former, the pain is generally to be found at the apex of the right scapula. This pain is not increased by pressure; it is a case of myalgia and not of neuralgia. A great number of patients complain of this pain; it results from nervous strain or nervous irritation, provoked by an organic lesion. *Neurasthenia* and *dyspepsia* are the two great causes of the backache. Germain Sée added *anæmia* to these causes, but *anæmia* and *neurasthenia* have frequently *dyspepsia* for a common origin. The fatigue of nursing frequently provokes backache. In such cases nursing should be interrupted and preparations of iron given. The public often attributes this pain to the presence of phthisis, and the idea is sometimes correct, for consumption frequently follows phosphaturia and general *anæmia*. Backache announces the nervous strain of the individual. In other cases, the pain spreads out over the sides, indicating dry pleurisy or tuberculous toxæmia. Auscultation of the apex of both lungs should be carefully made, and arsenic combined with general tonics ordered.

In *hysteria*, backache is very frequent; it occupies the vertebral column and, limited to three or four vertebræ, the pain suggests the beginning of Pott's disease.

All of those cases should be treated on their merits, but where the cause is really *neurasthenia*, with insomnia, sensation of lassitude, &c., subcutaneous injections of lecithin, spermin, or glyco-phosphate of soda over the painful spot modifies the local pain and at the same time tones up the general condition. They succeed better than local applications. If these latter be used the following might be prescribed:—



Menthol, ʒss;  
 Guaiacol, ʒj;  
 Gomenol, ʒj;  
 Vaseline, ʒj;

or

Chloroform, ʒij;  
 Camphorated oil, ʒiiss;  
 Ext. of belladonna; grs. xv;  
 Ext. of hyosciamus, grs. xv;  
 Ext. of opium, grs. xv.

The actual cautery, a small blister or a slight galvanic current will succeed if ordinary treatment fails.

The pain in the lumbar region is frequently caused by rheumatism. Sudations and local injections of salicylate of soda (salicylate of soda, ʒj, water ʒv) form an excellent treatment in such cases. Where the lumbar pain is caused by an effort or brusque movement, it is a case of traumatic lumbago, and is readily amenable to a few applications of the thermo-cautery, followed by a galvanic or faradic current.

In diabetes, lumbar pain has been frequently noticed, due, according to Willis, to irritation of the nerves. Inflammation of two or more of the vertebræ has been mistaken for an ordinary lumbago. Every pain provoked by the movement of the vertebral column should be closely examined. Many cases of Pott's disease have been overlooked, the patient being believed to suffer from lumbago.

Another affection which gives rise to lumbar pain is cancer of the stomach, and frequently the patient will complain of nothing else, the gastric troubles being but vague at that early period of the disease. The pain, however, should not be confounded with that of neurasthenia. The latter is more dull, less paroxysmal, and disappears during sleep, whereas the pain of cancer comes in stabs, awakens the patient in the night, making him cry out. The only treatment in this case is by injections of morphia. In certain acute affections (small-pox, nephritis), pain in the lumbar region is complained of. Called to a man suffering from pain in the lumbar region as the result of cold, and whose eyelids are puffy, the urine should be examined for albumin.

### Germany.

[FROM OUR OWN CORRESPONDENT.]  
 BERLIN, July 10th, 1904.

At the Surgical Congress Hr. Kuffner, Tubingen, discussed

#### THE GLYCOGEN REACTION OF THE LEUCOCYTES AND ITS SIGNIFICANCE IN SURGERY.

He said that it was known that Ehrlich had shown the presence of an iodophile substance in the leucocytes. This substance was said to be increased in some diseases, and its appearance was said to be proof of suppuration. The speaker had examined a series of 470 cases as to whether the glycogen reaction was really such a proof, and from his examination he must say it was not. It was always present in acute inflammations, whether there was suppuration or not; it was thus present in every case of appendicitis. The reaction was useless also in superficial suppuration. A negative finding was also without significance, as it could not be found in some cases of abscess. He found it comparatively frequently in tuberculosis—*vis.*, in 72 cases. Here it perhaps might serve as a proof of mixed infection, but even here it was occasionally absent. The reaction was of more value from a prognostic point of view, in so far as a diminution of the reaction after operation corresponded to cessation of the inflammatory process. The reaction could not, therefore, be recognised as a clinically important sign.

Hr. Rehn, Frankfort, spoke on

TUMOURS OF THE BLADDER IN COLOUR WORKERS. He said that he had already (in 1895) reported on cases of bladder tumour in aniline factories. He now reported on twenty-three cases. Such cases, in the speaker's opinion, would still further increase the longer such factories were in being, and the longer workpeople were employed in them. These bladder tumours were only observed in factories where aniline and its homologous and allied substances were prepared. As regarded the frequency of the disease he had instituted a collective investigation which had been extended to England. As regarded the length of time people had worked in such factories before the disease appeared, the shortest period was nine years and the longest twenty-two years. Five of the patients had papillomata, two of them afterwards becoming malignant; of the remaining eighteen, one suffered from sarcoma and seventeen from carcinoma. In four cases the carcinoma was multiple. The prognosis was unfavourable. Eleven of the cases had died.

Hr. Strauss had recently seen such a case. It occurred in a man who had been employed in a benzidine factory for twelve years, and who had passed portions of carcinoma in his urine a year before operation. The cystoscope showed a large tumour with intact bladder mucous membrane. The man had retention of urine from blocking of the outlet. The operation showed that the whole mucous surface of the bladder was healthy, that the whole bladder was filled with a tumour of soft consistence, and that the pedicle of the growth was only the size of a shilling piece. Near the pedicle was a small hard tumour, which had penetrated the submucous tissue, and which proved to be a carcinoma.

Hr. Küttner found it strange that such tumours were limited to the bladder area, and that they did not occur in other parts of the tract washed by urine.

Hr. Bardenheuer, Cologne, had seen and operated on two such cases. One of the patients soon died of recurrence, the other was still in good health after three years.

Hr. Schwerin said that the managers of colour factories had set experiments on foot with a view of preventing the disease. For years animal experiments had been carried on with a view to determining the exact cause. They had not succeeded in causing such tumours to grow, probably because they took too long to originate and the animals could not be kept alive long enough for such growth to begin.

At the Free Society of Surgeons Hr. Neumann spoke on

THE DIAGNOSIS OF DISEASES OF THE PANCREAS. (a) Pancreatic cysts that had developed towards the right, so that they gave the impression of renal cysts, and especially when at operation they were attached to the lower pole of the kidney, lay retro-peritoneally behind the cæcum and ascending colon. The pancreatic ferments would be found in the contents. (b) Symptoms of ileus with rise of temperature. At a laparotomy there was occlusion by a band; on separation of the band a stool followed. After a few days vomiting returned. A cystic tumour in the upper part of the abdomen. Suturing in of the cyst lying behind the peritoneum. The day after a brown fluid escaped with a penetrating odour. The right kidney not to be felt. The cyst contents had no pancreatic reaction; but neither chemically nor microscopically was there any indication of its origin. After some time pyonephrosis of the right kidney. Later on extirpation of the kidney. The original cyst, the position of which corresponded to a cyst of the pancreas, was a

paranephritic abscess that had developed towards the middle line.

He had recently operated on three cases of acute hæmorrhagic pancreatitis. All three died after temporary improvement in a state of diabetic coma. On post-mortem was found a large infarct of the liver.

Hr. Braun said that a boy had been trodden upon by a horse over the epigastrium a fortnight before admission, and peritonitic symptoms had come on. There was bulging of the epigastrium which was connected with the liver. Laparotomy was performed. There were distinct fatty necroses, and a cavity behind the stomach filled with a tinted secretion that contained pancreatic ferments. Drainage of the cavity was performed and recovery took place.

Hr. Koite related a case in which everything agreed with a diagnosis of cyst of the pancreas. The tumour was tapped, then incised, when there was excessive bleeding. The pancreas was packed, but the patient died from hæmorrhage. After death the pancreas was found to be healthy, and also the left kidney, but on the other hand the left suprarenal capsule was absent. There was carcinomatous growth in the wall of the cyst. He had seen two pancreatic cysts developing towards the right, but both were of a malignant nature.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 10th, 1904.

#### THE ACTIVITY OF FLUORESCENT SUBSTANCES.

IN the Congress for Internal Medicine, Tappeiner gave a number of demonstrations to prove the activity of fluorescent substances on the amœba. The sun's rays are equally as potent when acting through rarefied air. When applied to fish or the flagellata in this manner, a few days is sufficient to kill; in frogs and the paramœcium caudatum the time is four times as long, and he concludes that the higher animals are decidedly less sensitive to the influence of photo-dynamic substances than the lower.

Again, the enzymes, such as trypsin and diastase, lose their normal activity after a few hours' exposure to ordinary daylight. The virulence of ricini, diphtheria, and tetanus toxins can be quite destroyed by the presence of a fluorescent substance. He accordingly demonstrated dogs and guinea-pigs to which he had administered fatal doses, while the control animals died within a short time after administering the toxin. For this purpose the least refracted rays are the best, as they penetrate deepest into the tissue. As might be expected, the power of absorption is another factor that must be considered. If the tissues be painted with an eosin solution, through which the light must pass to act on any of the above toxins, the result will be negative, as the photo-dynamic power of the rays is abrogated by absorption. He affirms that the efficacy of photo-dynamic material increases by the reduced intensity of the fluorescent process.

This knowledge of fluorescent substances may yet explain many of the cures effected in cutaneous diseases. Thus four applications of the rays after painting a carcinomatous growth with eosin were effectual in curing the patient. This painting with an eosin lotion is particularly efficacious in labial and nasal carcinoma. In vulval or mammary carcinoma no evidence of success is yet forthcoming. Lupus is greatly benefited by this method, while the intensity of the secondary symptoms in syphilis are greatly reduced by its application. The efficacy of quinine in malaria is also accentuated, as the light acts effectually on the virus.

Seifert agreed with Tappeiner and related cases of lupus and sycosis non-parasitaria, which he had cured after eight applications.

#### ERYTHEMA INDURATUM SCROFULOSORUM.

Ehrmann presented three cases of Bazin's erythema scrofulosorum. This disease, he said, in prefacing his remarks, was first described by Bazin about 1860, although it appears to have been common enough before this time in both Germany and Austria. The disease declares itself on the extremities and less seldom on the trunk, in the form of walnut swellings, red at first, but soon taking on a brown knotty colour with a central part that breaks down in a cheesy discharge. It occurs commonly in people with all the symptoms of tuberculous scrofula, which will persist for years, and often recede under iodide treatment. The Röntgen rays seem to make them disappear promptly, but they unhappily soon recur again.

These cases were first diagnosed as syphilitic gummata, which was subsequently modified to erythema nodosum and scrofuloderma. Localisation was against syphilis, although the colour was in its favour, but mercury had no effect on it, though iodide had after a time. Against the nodosum theory the chronicity and hardness was fatal. The colour of erythema nodosum is red, passing into a violet colour, and finally appearing as a bluish-green surface, as in erythema contusiforme. Scrofuloderma is sharply separated by the ragged softening of the centre, whose perforations are often numerous, with irregular openings, which are often covered with the same thin, ragged pellicle; and no tuberculous bacilli are to be found in the discharge.

Neisser said that he recently had a similar case that was diagnosed as syphilis at the beginning, but was detected by the presence of tuberculous nephritis.

Schrötter said he recollected a case in 1869 that came into Professor Dittel's wards with sores on the abdomen, and no proper classification could be arrived at. Shortly afterwards hoarseness set in which resulted in ulceration of the arytenoid cartilage, which confirmed the diagnosis of syphilis. Anti-syphilitic treatment soon cleared the abdomen and throat. He considers Ehrmann's case to be of a similar character.

#### SEPSIN AND DECOMPOSING SUBSTANCES IN BOWEL.

Faust drew the attention of the meeting to sepsin, which, he said, was similar in composition to the toxin found in meat and an active poison when introduced into the organism by the glands or gastro-intestinal canal. Bergmann obtained a crystalline substance a few years ago from five grammes of yeast, which he designated sepsin, having the formula  $C_5H_{14}N_2O_2$ , from which cadaverin,  $C_7H_{14}N_2$ , can be obtained. Faust thinks this sepsin is the active principle of decomposition in the animal as yeast is the active agent in the vegetable world.

#### DIAGNOSTIC ASPIRATION OF CRANIUM.

Neisser next introduced the "probe puncture" of the cranium, which he had performed 120 times with the object of discovering the real cause of cerebral disturbance. With modern appliances this diagnostic operation can be performed almost with impunity, as the dura mater need not be injured in the hands of a skilful operator. The cranium being a hard, unyielding covering conceals all morbid changes from the surgeon, but as soon as he reaches the soft covering of the encephalon any bulging reveals abscess, hæmorrhage, or any change in the state of the vessels. There are many old products, both extra- and intra-dural, that can be diagnosed in this way that would never have come to light till after the post-mortem. Meningeal cysts and tumours can be diagnosed and removed at

the same time when found necessary. By this means he has often removed 50 c.c. of fluid and preserved life. Abscesses cannot be diagnosed with certainty, and must be probed first.

He would not say this probing was perfectly safe, nor would he encourage it without sufficient reasons, although he had only two deaths in all his operations.

#### NEW HOSPITAL.

On June 21st, Hr. Hartel, the Minister of Education, laid the foundation stone of the new "K. K. Allgemeinen Krankenhaus," which the Viennese look forward to as a new epoch in the calendar. The Kaiser was unable to be present in person, but the enthusiasm lacked nothing in his absence.

## The Operating Theatres.

### NORTH-WEST LONDON HOSPITAL.

**REMOVAL OF THE TONGUE FOR EPITHELIOMA FOLLOWING CHRONIC GLOSSITIS.**—Mr. MAYO COLLIER operated on a man, *æt.* 74, this being the third time he had operated on this patient for a definite hard mass on the fore part of the tongue. Mr. Collier said this was the third operation, the first two having been twelve and twenty-four months ago respectively. This case, he thought, was of considerable interest, in so far as the tongue had been watched by him for the last ten years. The patient had always enjoyed good health, excepting having suffered from occasional slight attacks of rheumatism, associated with a gouty tendency. In the last eight years he had complained of soreness of the tongue, for the relief of which treatment had apparently failed. The area of soreness was limited to the anterior half, the upper surface, the tip, and the borders. Effervescent wines, vinegar, salt, pepper, mustard, or any pungent substance caused extreme pain. Menthol, cocaine, chromic acid, and various other remedies had been applied by Mr. Collier without the smallest benefit. Four years ago a distinct white plaque appeared on the left of the median raphe; this was followed a year afterwards by a second plaque, below and external to the first. Associated with these plaques were several areas denuded of epithelium, causing the tongue to be extremely sensitive to pressure or contact. Mr. Collier, having his suspicions as to the nature of the upper plaque, excised this area down to the muscular tissue. It was found on microscopical examination to be a typical commencing epithelioma, which had not yet invaded the muscular tissue. The general glossitis was not improved by operation, and the tongue still remained as tender and sensitive as before. Twelve months afterwards the second plaque, below and external to the first, appeared to become more marked, and seemed to extend laterally. Mr. Collier again operated and removed the second plaque by a more extensive incision. This also was found to be commencing epithelioma. After the second operation Mr. Collier lost sight of the patient until quite recently, when the man presented himself with well-marked hardening and thickening of the tip of the tongue some little distance from the sites of the two previous operations. Mr. Collier said that nothing less than an extensive operation in this case would be of any avail, but as the patient expressed his unwillingness to undergo any operation which would prevent his feeding himself or speaking, and as his age was now 74, and there was no evidence of glandular infection, Mr. Collier contented himself with removing about half the tongue by a V-shaped incision, so as to include the areas of the two previous operations. The present operation was commenced by passing a stout

ligature through the growth and the tip of the tongue, the sides of the base of the organ were brought forward and steadied by two pairs of clutch forceps held by two assistants. This steadied and held forward the root of the tongue, and allowed the easy introduction of the deep and superficial sutures and the application of any ligatures to the vessels. Mr. Collier said that the application of clutch forceps to the sides of the base of the tongue during this operation was a matter of the utmost importance; it facilitated respiration, and the admission of the anæsthetic; it controlled hæmorrhage from the linguals, and prevented blood from passing into the larynx; it rendered the application of ligatures to the linguals perfectly easy, and it allowed the putting in of sutures and the adjusting of the cut surfaces with as little trouble as would have been experienced in adjusting a wound of the skin. The incisions were made with an ordinary pair of scissors, so as to leave a lateral flap on each side which could be adjusted to form a new tip. There was practically no hæmorrhage during these incisions. The linguals were easily found and ligatured, and the flaps were brought together by deep and superficial sutures with great ease and rapidity. Mr. Collier thought that with the precaution of holding steadily the base of the tongue with clutch forceps and with the aid of good assistants, the operation for the removal of the tongue was divested of all anxiety.

**ERRATUM.**—Owing to a printer's error, a line of the MSS. was omitted in "The Operating Theatres" of June 22nd. On page 665, second column, after line 9, the following words should come: "upon the hypoglossus muscle. With regard to the." In line 10, there should be a comma after "hypoglossal nerve," not a semicolon.

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## The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 13, 1904.

### NOMENCLATURE IN PULMONARY TUBERCULOSIS.

At the present day, when sanatoria for pulmonary tuberculosis are springing up like mushroom all over the country, there is a distinct want of some general system of nomenclature if definite information is to be gained of the results of their

work, especially if comparison is to be made between different institutions. It is customary to speak of three stages in the pathology of the disease, but these stages, like the three weeks of typhoid fever, are merely arbitrary periods fixed for the sake of convenience, and everyone conversant with the manifestations of tubercle knows that the three stages often co-exist in the same lung. The same may be said of the term "cured"—it is convenient practically, but it is scientifically unjustifiable. No patient who has suffered from tuberculosis ever returned, or ever will return, to the *status quo ante*. "Arrest" is certainly more accurate, but what one man might call arrest, another might term, with equal propriety, quiescence, and so on with every phase of the disease. It is, then, we think, desirable that some uniformity should be introduced in the terminology of the clinical conditions of tuberculosis of the lungs, for while one sanatorium may be turning out 50 per cent. of cures, another of equal repute, but with a more fastidious medical officer, might not return 5. Both practitioners might be equally conscientious, but their views as to what constituted a "cure" might differ enormously, and the comparative merits of the institutions they served would be liable to be disproportionately assessed by their committees and the public. Whatever opinion may be held as to the appropriateness of sanatoria for dealing with the disease, these institutions are now on trial in Great Britain; some persons have put forward the most optimistic predictions as to their potentialities, others are filled with gloomy forebodings. At all events, for good or for evil numbers of public and private sanatoria are now established, and it will be instructive to be able to review the record of their attainments after they have dealt with a sufficiently large number of cases to enable a fair judgment to be formed. But no such review will be possible unless a uniform system of terminology is adopted for expressing the conditions of the patients on entry, on discharge, and after such a period of years has elapsed that the effect of the treatment may be manifested as to its durability. It is well within the experience of not a few medical men that the "cured" or "arrested" patient has in some instances left the sanatorium only to die a few months later of acute general tuberculosis, so that no fair view of the success of sanatorium life can be taken till the patient has resumed his daily duties for some considerable time after discharge. In pressing for some definite system of nomenclature one would suggest that some central authoritative body, say, a medical committee of the National Association for the Prevention of Consumption, should issue a scheme detailing the various terms which should correspond to certain clinical conditions, and that each sanatorium should make returns under those headings. No such scheme could be absolute or perfect, for clinical conditions do not, from their very nature, lend themselves to exact classification, but some good, broad, working terms might be suggested to which medical officers

should conform as far as possible. As a model for such a scheme the classification of the stages of pulmonary tuberculosis issued last April by the American Climatological Association might be adopted, for although objection may be taken to some of their definitions as being arbitrary, at least they submit terms in which the general results of treatment can be commonly expressed. This Committee take as their basis of nomenclature eight phases in the history of the disease, the incipient, the first, second, and third stages, the progressive, the quiescent, the arrested, and the apparently cured, and to each of these they attach a definite meaning, expressed as to symptoms and physical signs. Thus, the incipient includes those cases in which there are "slight physical and subjective signs, with history indicative of pulmonary tuberculosis. Sputa, if present, without bacilli"; the arrested, "absence of all constitutional symptoms; expectoration and bacilli still present; physical signs may or may not persist; foregoing to have existed for at least three months"; the apparently cured, "all constitutional symptoms and expectoration, with bacilli, absent for a period of two years under the ordinary conditions of life," and so on. These definitions may not be ideal ones, but they are comprehensive and easily understood, and it would be a great advantage if they, or some such terms, could be generally adopted over here. Without some such system it will be impossible to form an intelligent opinion of the results of sanatorium-treatment as a whole, and equally impossible to decide on which side the advantage to the patient inclines with regard to the different types of sanatoria advocated by different authorities.

#### SUICIDE.

THE recent discussion at the Medico-Legal Society on the question of suicide brings this interesting subject forward again in all seriousness and with all its puzzles. The word "suicide," as Mr. Henslowe Wellington pointed out, means self-murder, and not simply self-killing, so that the stereotyped finding of the coroner's jury, "Suicide whilst temporarily insane," is paradoxical, though one cannot doubt that the verdict is generally put forward in consideration of the feelings of the distressed relatives, and not necessarily as the result of conviction. For, whatever the alienist may say, there is always a large margin of cases of self-destruction in every country for which it is difficult, indeed impossible, to account for on the ordinary ground of insanity. No one doubts that insanity, temporary and permanent, is the usual cause that incites people to self-destruction, and that premeditation and planning in connection with the act are quite reconcilable with mental aberration. The classic case of the Naples shoemaker is quite sufficient to establish the latter point. This individual first showed his claim to insanity by castrating himself and flinging the genitalia out of the window. After a year's treatment he recovered, and then he

conceived the idea that God had commanded him to suffer on the cross. For two years he worked silently making arrangements to fulfil this behest, and when he had completed his plans he was discovered one morning, nailed to a cross with a stab in his left side, hanging out of his window. The whole business was so cleverly contrived that he had managed, after completing the crucifixion, to shift the cross out of the window by movements of his body. Although rescued, he persisted in refusing food till he died. But though deliberation in preparation and determination in execution are quite compatible with insanity, there remains a number of cases in which the murder of the "self" is as true a murder as the murder of another, and it is just this group of cases that are the bane of every civilised state. Suicide among savages is said to be very rare, but in every country of which we have historical record it has been more or less rife, and in tables of figures for 1882 we find that suicides in Europe vary from 21 per million per annum in Ireland to 371 per million in Saxony. Admitting that a large number of these cases are due to mono-idealism, resulting from strain and stress, there are still many in which the evidence of rationalism is so well marked that it cannot be reasonably gainsaid. We might take the case of Whitaker Wright, for example. This man had been living for years in the lap of luxury, held in esteem and confidence by many of the highest and most trusted in the realm, and in perfect domestic felicity. When brought to the bar of justice he conducted himself with dignity, and fought his case with eminent sanity, but he had obviously decided that—to him—an adverse verdict with all that it entailed would rob him of all that life held dear, and he made his preparations accordingly. After sentence was passed, he quietly and composedly carried out his fell purpose. It is as impossible to attribute a self-murder of this kind to insanity as it is those of the Japanese officers who prefer suicide to falling into the enemy's hands, or those of the Carthaginian generals whose etiquette it was to destroy themselves if beaten in battle. We get to this position, that strong-minded men deliberately prefer death to certain alternatives, and they do so while in full possession of their faculties. They are no more insane than the man who volunteers to lead a forlorn hope to certain death—they prefer death to what they consider disgrace. In certain States self-destruction has not only been considered justifiable, but even honourable; in the island Ceos, the inhabitants were expected to poison themselves at the age of sixty to make way for younger people, and when Marseilles was a Greek colony, poison was provided by the Senate for those whose motives for killing themselves met with the magistrates' approval. In modern countries the practice of suicide, not merely as a manifestation of insanity, is certainly increasing, and although in Great Britain and America it has not reached the proportions that it has assumed on the Continent, it constitutes a

sufficiently serious problem. The epidemic, of imitative, tendency of suicide, especially of a plausible suicide, is well recognised, and it is a practice that gets more and more apologists as time goes on. It is not a problem that is easily solved, how best to check this morbid tendency. Laws have been passed in many countries to punish the would-be suicide, and to dishonour him and his family, but though drastic measures of this kind are said to have been successful in Egypt and Miletus in the past, they have certainly proved ineffectual in England. One exciting cause in modern countries that is within control is the liberty accorded to the Press to report with lurid detail and in large type the details of sensational suicides, but the question passes out of the realm of medicine when it deals with other than the self-destruction of the insane. Our duty ends when we have shown that there are rational suicides as well as insane ones, and that the verdict of "temporary insanity" is often unscientific, and, therefore, not to be commended, even on grounds of the broadest humanity.

#### THE IODISED PACK IN THE TREATMENT OF PUERPERAL SEPTICÆMIA.

IN spite of numerous and often drastic methods of treatment, puerperal infection remains a grave complication of childbed. Although in hospital wards the mortality has been reduced to about 1.5 per thousand, in private practice the death-rate is not perceptibly less than before the introduction of antiseptics, no doubt simply because advantage is not taken, and in many instances cannot possibly be taken, of their action. Injection of antistreptococcic serum, though occasionally effectual, has proved untrustworthy and is at best no more than a useful adjuvant. Curettage of the uterus, though a rational procedure, is attended by risks so considerable that eminent authorities have expressed their disapproval of its use. It is obvious, indeed, that while digital removal of placental *débris* fulfils an urgent indication, neither it nor curettage can do much in the direction of arresting the invasion of the uterine sinuses and crypts by the microbial host which has gained a footing. Antiseptic irrigations are, no doubt, useful as far as they go, but their influence is extremely ephemeral, and during the intervals the infective process runs its course unhindered. It is evident that if we wish to exert a definite effect on the septic process we can only do so by maintaining the germicide in contact with the infected walls of the uterine cavity. This is not altogether a novel suggestion, but so far as we are aware it is one which has not hitherto been systematically practised, yet the cases which we publish elsewhere, (a) reported by Dr. Cabanes, of the Medical School of Algiers, seem to show that it is possible to secure extremely satisfactory results by a procedure based on this principle. Briefly described, his method comprises the cleansing of the uterine cavity, and packing it loosely with gauze steeped in a 4 per cent. solution of iodine and

(a) See "Clinical Records."

iodide of potassium in sterilised water. The dressing is renewed every twelve hours or so until apyrexia is obtained. We gather that the treatment has been adopted in a fairly large number of cases with uniformly good results, although in several instances the virulence of the infection was conclusively demonstrated by the death of several patients infected by the same midwife, but who had not been subjected to the treatment in question. The experience of Dr. Cabanes shows first of all that the treatment is free from any risk of its own, and the promptness with which the symptoms of puerperal endometritis yielded to the dressing is equally conclusive. The method is quite within the scope of the average obstetrician; it necessitates no special appliances, and the extra trouble which it entails cannot weigh with us in view of the extreme gravity of the complication. The method is applicable even when the infective process has extended beyond the limits of the uterus proper, for although it may not directly modify the subsequent course of peri-uterine inflammation, the removal of the original and principal focus of infection cannot but exert a favourable influence on the constitutional condition which, after all, constitutes the gravest part of the problem. We see no reason to suppose that the method would prove less serviceable in other hands than it appears to have done in those of Dr. Cabanes, and its simplicity is a further reason for giving it a trial.

### Notes on Current Topics.

#### Teacher and Student.

AMONG the many topics touched on in Dr. Musser's thoughtful and eloquent Presidential Address to the American Medical Association, there is none demanding graver attention from the teachers in our hospitals and medical colleges than the question of the attitude they should adopt towards unfit students. Every conscientious teacher must, from time to time, be brought into contact with students who, by their character, whether the fault be mental or moral, must be regarded as unfit to become members of the medical profession. It may be that there is an almost entire lack of power of concentration and of memory, accompanied by stupidity, of such a degree as to render the acquisition of the necessary knowledge an impossibility. On the other hand, there may be such moral obliquity, and absence of honesty and frankness, as at any rate make professors hesitate to allow the *imprimatur* of their school to be attached for life to a man of such character. In both cases there is great difficulty in deciding on the course to adopt. It is true that in the former case the qualifying examinations will, of themselves, weed out unsuitable candidates, but it would, in many instances, be kinder and more just to warn the man of his ineligibility in his early years of study than to allow him to waste his best years in fruitless toil, presenting himself again and again for a test he can never satisfy. There are few men more to be pitied

than the "chronic medical students" who at four or five and twenty discover that the attainment of their goal is an impossibility. They have wasted five or six years in work dull and useless to them, and this waste might have been saved by friendly but firm advice at the outset. With regard to students whose moral character renders them unsuitable, the case is less hard, though to them, too, it would be bare justice to announce in the earlier years of their studentship the decision of the authorities of their school. We recognise with Dr. Musser the impossibility, in matters of individual character, of suggesting anything in the way of a general line of action, but we think he does well in emphasising the enormous responsibility in making or marring men's lives which lies with every teacher of medicine.

#### A Remedy for Physical Deterioration.

A SPIRITED effort is being made by Dr. Henri Cazalis to lift the question of physical deterioration into a stage of practical activity, so far as France is concerned. He believes that the evil is largely due to the prevailing ignorance as to the baneful effects of alcoholism, of syphilis, and of tuberculosis. His plan of campaign, which was set forth in a recent communication to the Académie de Médecine, is worthy of careful consideration in this country, where the same causes are at work, and are at the present time claiming increasing attention. Dr. Cazalis proposes that the machinery of the State be made available for the dissemination of the knowledge which is so much wanted. He points out that since the immense majority of the male population are called upon to serve in the army or in the navy, there exists a ready channel for the education of the masses, and that so good an opportunity should not be wasted. He suggests that a short set of statements might be drawn up by the Académie with a view to their being appended to the soldier's or to the sailor's "livret." In this manner a definite impression would soon be made upon the entire community. Another important measure is suggested by the appalling lack of appreciation on the part of those who contemplate matrimony of the responsibilities which they incur in relation to the health of their future offspring. Cazalis does not on this occasion press his well-known advocacy of a preliminary and voluntary exchange of certificates of health; but he considers that the State might so far intervene for the prevention of any further deterioration of the race as to provide the recipients of marriage certificates with some appropriately worded reminder of those principles which most closely affect the health and vitality of the future generation. A third suggestion, which is intended for the benefit of mothers and nurses, is so much to the point, whilst entirely free from any possible objection, that it has already been adopted in principle by the Municipal Council of Paris, and is likely to be soon adopted throughout the land. It is recommended that a set of instructions as to the management and

feeding of infants be drawn up by the Académie and supplied to parents or to their representatives when making, at the Mairie, the official declaration of a birth. Dr. Cazalis is to be congratulated upon this instalment of success in his philanthropic and most praiseworthy endeavour. The best results may be expected from some such self-working system of education in matters of health, and it cannot be doubted that the soundness and strength of the race will benefit in a full measure from this organised diffusion of elementary knowledge of family hygiene.

#### Public Vaccinators' Fees.

THE Departmental Committee that has been inquiring into the subject of the fees paid to public vaccinators and the other expenses entailed on the guardians by vaccination generally has made its report, which is now being considered by Mr. Walter Long and his advisers. What the report contains is not, of course, known, but according to Mr. Long's own statement at the time of its appointment, the Committee owed its *raison d'être* to a desire to cut down expenses. A vigorous protest was entered in these columns at the time against any attempt being made to reduce the fees now paid to the public vaccinators, and it is to be hoped that it is not too late to re-emphasise the point before the Local Government Board decision is made. The 1890 Act entailed fresh and very onerous duties on the public vaccinators, duties which were placed on them entirely in the interests of the parents of children, and not at all in their own. It was, then, only fair that their fees should be raised, for a medical man's time is his money, and the amount of time spent in going from house to house is obviously tenfold more than that spent in vaccinating children brought to a vaccination station. The Act has certainly disposed of the last reasonable objection on the part of the poor to have their children vaccinated, and it has certainly resulted in a large increase in primary vaccinations. It would, therefore, be in the nature of a breach of confidence to revert to the old scale of fees, or anything like it, and any such proposal would lead to a very justifiable outburst of indignation in the profession. The small-pox scares that have agitated the community during the few years since the passing of the Act have naturally led to a large number of re-vaccinations, and the expenses in the administration of the Act have risen proportionately. But these expenses must be considered as abnormal, and the money thus spent is surely far better utilised than in building temporary hospitals for small-pox patients and paying for their nursing and maintenance. Any attempt to go back on the contract under which public vaccinators were appointed would be viewed with unanimous displeasure by the profession.

#### The Thought of Death.

A LAY contemporary has been collecting opinions from various sources with a view to ascertaining what death means to the dying man or woman.

It is a solemn subject, and one that easily lends itself to morbid treatment and speculation, but at the same time it is one that may not unprofitably engage the thoughts of serious people. To those whose painful duty it has been to stand by the bedside of many a dying patient, as has fallen to the lot of most medical men in active practice, the actualities of the situation appear in a different light from that presented to the popular mind. There are, of course, many modes of death, which differ from each other in the widest possible manner. One man may be cut off from the enjoyment of (apparently) complete health and strength by an attack of syncope or cerebral hæmorrhage in a few seconds, whilst another dies by inches from malignant disease or tuberculosis. It is often said that death by drowning is a pleasant experience, and some persons who have been rescued after prolonged immersion have narrated happy dreams that have passed through their mind, until rudely awakened therefrom by their rescuer. This, however, is not the common lot of the nearly-drowned, and in any case the preliminary stages of asphyxia—whether by filling the air-passages with water or by any other means—are, though fortunately short, attended by most horrible sensations. The actual passage from life to death in the vast majority of cases, if not actually all, is not only painless, but occurs during a period of unconsciousness. The transition causes as little disturbance subjectively as the passage from wakefulness to sleep, and the only people who suffer in anticipation are those whose illness is accompanied by clouding of the intellectual faculties. Nor do these always suffer, for we have it on record that the celebrated William Hunter said to his friend Combe, shortly before his death, "If I had strength enough to hold a pen, I would write how easy and pleasant a thing it is to die."

#### Chalfont Epileptic Colony.

It was a bold and humane step that the founders of the Chalfont Epileptic Colony took when they inaugurated an establishment where useful employment, combined with skilled supervision, could be exercised over the unfortunate individuals whose liability to fits rendered their existence both dangerous to themselves and useless to others. The recent meeting of the governors calls attention to the fact that its aims are not only being fulfilled, but that more is being learned by experience of the capacity of epileptics and of their suitability for various tasks. The men are employed in a number of trades, such as carpentering and painting, beside farm-labouring, and the women are kept occupied with laundry, needle and housework. It can scarcely be hoped that the colony will ever be quite self-supporting, when all the circumstances under which it carries on its work are considered. Thus Dr. Aldren Turner reports that 29 per cent. of the epileptics suffer so much from mental impairment that their capacity for work even under direction is very small, whilst of the remaining 70 per cent, 57



suffer from more or less intellectual defect. This leaves, therefore, only 13 per cent. who are really averagely intelligent and capable. The work done at Chalfont has had good effects in several directions, notably in stimulating the London County Council to establish a similar colony at Horton, and it is to be hoped that now that it is evident that the epileptic can be made a useful member of society, more of these institutions will be built and equipped in different parts of the country. One of the best tests of the degree of civilisation that a State has reached is the way in which it treats its halt and maimed, and no more enlightened, humane and beneficent work could be conceived than that of making the epileptic a happy and useful member of the society in which he lives.

#### The Foundation-Stone of New St. Bartholomew's Hospital.

ON the 5th inst. the King and Queen visited St. Bartholomew's Hospital for the purpose of laying the foundation-stone of the reconstructed Hospital. On arrival Their Majesties were received by the Prince of Wales in his capacity of President of the Hospital, accompanied by the Princess, together with a reception committee of the Chairman, Sir Trevor Lawrence, the Senior Almoner, Mr. Alderman Alliston, Sir Ernest Flower, M.P., Dr. Gee, Senior Physician, and Mr. John Langton, Senior Surgeon. Prayers were read by the Bishop of London, and an address from the Governors was read by the Prince of Wales. The King then duly laid the foundation-stone, an immense block of polished red granite. An interesting little ceremony followed in the shape of the conferring of a Governorship of the Hospital upon the Queen. This is the first occasion upon which that qualification has been bestowed upon a lady. The total estimated cost of the scheme is about half a million. The City was *en fête*, and the scene at St. Bartholomew's was of a most brilliant description, worthy of the records of the ancient City with which the Institution has been for so many centuries connected.

#### The Bacteriology of Pneumonia.

FOR many years there has been waged a contest as to the causation of acute pneumonia, between those who regarded Fränkel's diplococcus as the sole bacterial cause, and those who gave a similar pre-eminence to Friedländer's pneumo-bacillus. In general, opinion seemed to have settled in favour of the diplococcus, though from time to time a case was reported where it was apparently absent, and no sufficient pathogenic germ could be found except the pneumo-bacillus. Kokawa, however, has recently pointed out that there are in reality two types of the disease, differing markedly in pathology, one being due to each of the two organisms mentioned. As points of difference, he draws attention to the greater production of mucus in the bacillary than in the coccal infection, and to the fact that in the former there is usually more of the lung involved. In

it, too, hæmorrhage into the alveoli is usually less-marked, and, consequently, during the stage of grey hepatisation there is less fibrinous coagulum. The bacilli are found embedded both in the leucocytes and in the epithelial cells, which usually show vacuoles. It is well known that the diplococcus may cause very varied infections, and so, too, in the case of the pneumo-bacillus, Kokawa brings evidence to show that it may be the causal agent in pleuritis, pericarditis, endocarditis, otitis media, and other inflammations.

#### The Health of Dublin.

IT is refreshing to find that the death-rate in Dublin has at length reached a reasonable figure. In the week ending July 2nd it was only at the annual rate of 16.7 per 1,000, being a little lower than that of London, while the mean rate during the corresponding week of the past ten years was 21.9. We have no reason to suppose that the drop in the death-rate is more than a temporary accident, depending to great extent on the weather. A large proportion of the deaths in Dublin are due to diseases of the respiratory system, and during the mild weather recently enjoyed these are naturally lessened in incidence. The real *crux* of the health question in Dublin is, of course, the housing problem, and to grapple with this no serious attempt has yet been made. It is true that the Corporation and several voluntary bodies, such as the Association for the Housing of the Very Poor and the Alexandra College Guild, are engaged in supplanting condemned tenements by suitable sanitary dwellings. Their efforts are, however, on such a small scale that they can only be regarded as instructive and successful experiments, for at the present rate of progress it would take a little over a century to substitute a sufficient number of artisans' dwellings for slum tenements to supply the working population of Dublin.

#### The Recent Hæmatogen Trial.

THE facts of the recent Hæmatogen trial at King's Bench will be fresh in the minds of many of our readers. The defendant Bauer, of Gebrüder, Bauer and Company, has drawn attention to our comments on that action contained in our issue of June 22nd, 1904. The paragraph in question mentions briefly the grounds of action and issue of the trial. It then dwells upon the hardship entailed upon the plaintiff by the adverse verdict, which deprived him of his trade mark. The only passage that can conceivably be construed as reflecting upon the defendant Bauer is the following:—"The injustice arises out of the English system which allows any trade mark to be registered, but grants it no subsequent authority or support. If Hommel's mark is bad now, it was bad at the time of registration. Why should an honourable firm be permitted to spend large sums of money in introducing a legitimate article, recognised by the medical profession, only to find out in the course of a costly trial in the High Courts that their trade mark may be used by

any unscrupulous competitor?" These sentences were obviously intended to be general in their application, and we can assure Mr. Bauer there was no intention to include him amongst the class indicated by the words "any unscrupulous competitor." If our words are capable of that interpretation we regret the circumstance extremely and willingly withdraw the passage *in toto*. It would be contrary to the policy and principles of THE MEDICAL PRESS AND CIRCULAR to exceed in any way the limits of absolutely fair comment. The English system of permitting the registration of trade marks without attempting to test their validity seems to us to invite strong editorial comment. We regret if any passing ambiguity of expression should have given rise to misunderstanding by suggesting a particular application of what was advanced as a general proposition.

#### A Slander Case.

AN action for damages for slander which promises to be interesting to medical men is listed for hearing in the Irish Courts. Dr. FitzGibbon, a medical man residing in county Wicklow, is the plaintiff, and the alleged slander arose in a rather curious way. The plaintiff's dog had a fight with another dog, and came off victorious, inflicting wounds on the other's ear. These wounds were stitched and treated by the plaintiff, and the dog ultimately completely recovered. The defendant, however, a gentleman residing in the neighbourhood, is stated to have made remarks reflecting on the plaintiff's treatment of the dog, and in general of his skill as a surgeon. The damages claimed are small in amount, but it is the first case we remember where a medical man's professional treatment of an animal has given rise to an action at law.

#### The Diminishing Birth-rate.

THE fact that the birth-rate of the United Kingdom has been steadily falling for the last thirty or forty years must sooner or later be faced by the nation. Whatever the exact meaning of the handwriting upon the wall, it deserves careful and skilled investigation by our best scientific brains. Some months ago the subject was brought forward by Dr. Taylor, of Birmingham, who attributed the decline in the birth-rate to the use of preventive methods by married persons. Such practices he claimed to be productive of a host of physical and moral evils both to the individual and the community. His views were at once accepted by many Churchmen, more especially the Bishop of Ripon, and have excited world-wide interest and discussion. Dr. Taylor's views, however, are not to pass unchallenged by the medical profession. In the present number of THE MEDICAL PRESS AND CIRCULAR (July 13th, 1904), we print an article by Dr. David Walsh upon the subject. He agrees with Dr. Taylor's main proposition that the birth-rate has fallen 5·6 during the past half century. After that point, however, he claims that hardly a single statement of that writer will stand serious examination. To begin

with, Dr. Taylor has overlooked the fact that the total birth-rate includes illegitimate births, but he nevertheless took that total rate as the basis of his bald assertion that the birth loss of the United Kingdom is due to "causes operating on the married life of its inhabitants." Dr. Walsh advocates neither side, but simply weighs the arguments advanced. His closely reasoned article should be read by all interested in the subject. It is comforting to find that medical men do not all agree with Dr. Taylor in his doleful jeremiad on the wholesale lunacy and depopulation of the United Kingdom somewhere in the near future.

#### Fried Fish and Typhoid Fever.

OF late the sensational scare attributing typhoid fever to the eating of fried fish has once more gone the round of the lay press. When the suggestion was first mooted we expressed the most frank doubt as to the truth of any such connection. The fried fish theory originated some years ago in the attempt to run to earth a mysterious epidemic of typhoid fever in South London. At the time it was carefully investigated and reported upon by Dr. Waldo, the then Medical Officer of Health for Southwark. He came to the conclusion that the outbreak could not be connected with the fish shops, and, as a matter of fact, the agency at work in the spread of that particular epidemic remains a mystery to this day. As regards fried fish, it is, on the face of it, extremely unlikely that the typhoid germs could survive the process of cooking. It is suggested by Dr. Hamer, who first raised the alarm, that the typhoid bacilli left in the intestines of the fish are so protected that they remain alive and subsequently infect consumers. It would be hard to find fish cooked whole in that manner in any fried-fish shop in London. The trade is confined almost, if not quite, entirely to slices or fillets of large fish. Without absolute or overwhelming scientific proof it seems a thousand pities that the good reputation of so cheap and valuable a popular article of food should be endangered. Further, we venture to say that convincing evidence of the theory of the spread of typhoid fever by fried fish shops has not hitherto been forthcoming. The typhoid bacillus fortunately is not a salamander that can withstand a ten minutes bath of boiling oil.

#### Early Rising.

A CERTAIN old saw, inculcated by nurses and copy-books, used to make early rising an indisputable preliminary to health, wealth, and wisdom, and the medical profession, doubtless through stupidity and prejudice, have so far clung to this tradition that their patients have ceased to look to them for sympathy when they are indolent in their habits. However, times change, and doctors with them, and just as a straw shows which way the current is flowing, so do two pronouncements emanating from medical men—one in the North of England and another in America—indicate that the tide of opinion is changing. The English physician thinks that it is dangerous to health.

and even to life to get up in a hurry, whilst the American, an alienist, by the way, thinks that this way madness lies. "The free and lazy savage gets up when he feels ready, and rarely or never becomes insane." To be forced to get up early "grinds the soul, curdles the blood, swells the spleen, destroys all good intentions, and disturbs all day the mental activities, just as a tornado disturbs and levels with advancing ruin a forest of mighty pines." The pathology of this tornadoing American may not be very exact, but his poetry is inestimable, and it behoves one in the future to take care that the arrival of one's shaving-water in the morning is allowed to pass unnoticed, lest coagulation of the blood and congestion of the spleen bring one to a bad end. The virtuous wife who rose before dawn to give a potion to her maidens may now be bidden to lie a-bed until she feels inclined to get up, or a very limited number of rubies will outweigh her market value, and the "smart set" will be able to turn night into day without a quail of conscience or a tinge of remorse. When such "medical experts" are quoted in the daily papers, one can only animadvert on the wonderful progress of medicine since our fathers' time.

#### The Cause of Appendicitis.

WITH appendicitis on every side, and people keenly interested in the subject, it is natural that they should constantly be asking their doctor, "What is the cause of appendicitis?" The medical attendant, for his part, may either enter into a technical disquisition which may leave the inquirer about as wise as when he began, or he may take refuge in the prevailing ignorance of the profession, and answer, "Nobody knows." At any rate, the position is not an enviable one, and does not enhance his prestige. A paper by Dr. Rubin, of Chicago, in the *Medical News*, details some ingenious experiments made by himself with a view to discovering some mechanical explanation for the condition. The method he adopted was to cut out a portion of the gut, which included the cæcum and the appendix, from the cadaver, of a subject who had died of some affection not connected with the intestine. After washing the excised bowel, he placed in its lumen various objects, such as beans, peas, and shot, and then shook and rolled the intestine about in imitation of peristaltic movement. Although he used considerable force, none of the objects entered the cavity of the appendix. He then proceeded to blow out the bowel with gas, keeping the peas and beans still in the lumen, and when the inflation was complete, he proceeded to carry out the same shaking and rolling process. In nine out of ten experiments he found that the appendix became filled with shot, whilst in two even peas entered the cavity. The only case in which the shot did not enter freely was one in which the appendix was hypertrophied and had a stricture of the lumen, and even in this instance one small shot found its way in. It would seem, therefore,

that flatulence would be very likely to be a predisposing cause of appendicitis, and that the blowing up the cavity of the appendix with intestinal gas would enable portions of fæces and foreign bodies to gain access to it. If this be indeed the case, it may prove possible to avert threatened attacks of appendicitis by diet and drugs, but till something more definite is known, one must be content to follow the old course.

#### The Diagnosis of Beri-beri.

IN view of the recent outbreak of beri-beri which has occurred among the Chinese labourers imported into South Africa, a correspondent has written to the *Times* enclosing an extract from the address delivered by Sir Patrick Manson at St. George's Hospital on October 1st, 1897, in which the need for post-graduate instruction in tropical medicine was eloquently brought forward. Two years later the London School of Tropical Medicine was founded, mainly through the instrumentality of the Right Hon. Joseph Chamberlain, and in connection with the Seamen's Hospital Society; this institution has played a most important part in the education of medical men in tropical diseases. This fact would seem to have been forgotten by the writer of the letter, for he points out that beri-beri is common in the port of London, and implies that a correct diagnosis is seldom made. Were there no opportunities for seeing the disease and of receiving instruction as to its clinical and pathological features such an implication would be justified, but now that there are two schools of tropical medicine in this country there is no particular reason why all medical practitioners should not have a nodding acquaintance with the malady. Difficulty of recognition is most apt to occur when the disease appears in a sporadic fashion, for then it is only the more prominent symptoms which are especially noted, such as heart disease, dropsy, or peripheral neuritis. The presence of the last-mentioned symptom, when due to maladies other than beri-beri, is liable to be confounded with that affection. The three forms of the disease recognised by Cantlie, the wet, dry, and mixed, are not always separated one from the other, but the mixed variety is that most usually encountered. The presence of œdema limited to the front of the shins, the absence of knee-jerks, the existence of a patch of anæsthesia on the inner side of the calves, combined with some evidence of heart weakness, would lead one to suspect beri-beri in any given patient.

#### PERSONAL.

THE QUEEN has presented a signed engraving of herself to the Royal University of Ireland, through the Chancellor of the University, the Earl of Meath. Her Majesty is an Honorary Graduate of the Royal University.

HIS MAJESTY THE KING, accompanied by the Queen, on the 5th inst. proceeded in semi-state to St.

Bartholomew's Hospital, when he laid the foundation stone of the new additions to the present structure.

MR. E. B. P'ANSON, the architect of the new building, had the honour of a special presentation to His Majesty immediately before the laying of the foundation stone.

HIS MAJESTY THE KING presented £1,000 to the Building Fund.

HER MAJESTY THE QUEEN was presented with the first lady governorship granted by St. Bartholomew's.

W. H. CLAYTON-GREENE, B.A., M.B., B.C.Cantab., F.R.C.S.Eng., has been appointed supernumerary surgeon in charge of out-patients to St. Mary's Hospital, Paddington.

PROFESSOR JOHN SHOEMAKER, the distinguished American physician, was recently presented with a silver shield and a silver loving cup by the Medico-Chirurgical College of Philadelphia at a celebration of the thirtieth anniversary of his entrance into the medical profession. A brilliant function was held in the college, with the foundation and the development of which Dr. Shoemaker has been intimately connected.

THE Wightman Lecture of the Society for the Study of Disease in Children will be delivered at the Hotel Cecil on July 15th, at 6.30 p.m., by Mr. R. Clement Lucas.

THE Marquis of Londonderry, as President of the Board of Education, on the 11th inst. received a medical deputation in favour of the compulsory teaching of hygiene and temperance in public elementary schools.

THE Royal College of Physicians of London has announced the following lecturers for 1905:—Dr. W. C. Bosanquet as Goulstonian lecturer; Dr. W. H. Allchin as Lumleian lecturer; Dr. Norman Moore as Fitz-Patrick lecturer; Dr. Leonard E. Hill as Oliver-Sharpey lecturer; and Dr. W. H. R. Rivers as Croonian lecturer.

THE Earl of Derby, as Chancellor of the University of Liverpool, early in the present month presided at the first public conferring of degrees of that university, and was himself presented for the honorary degree of D.C.L.

DR. LOUDINI was recently entertained at a public dinner and presented with a purse of gold by the Liverpool University Association, on the occasion of his assumption of the office of Bursar of the University.

WE regret to announce that Mr. F. A. Barton, M.R.C.S., the well-known expert in airship matters, met with a serious accident last week owing to the explosion of a gas cylinder while engaged in filling his balloon. From latest accounts he is doing well.

DR. JAMES WALLACE, on the occasion of his departure from Stonehaven, has been presented with a silver tea-tray by his numerous friends and patients.

MR. WALTER C. C. PAKES, M.R.C.S., has received a handsome presentation in recognition of his services as medical officer of health to the Rand Plague Committee, a post which he has recently resigned.

MR. CLEMENT LUCAS presided at the biennial festival dinner of Guy's Hospital Medical College held on the 5th inst. at the Hôtel Métropole, London.

PROFESSOR GEORGE GAFFKY, who has left his Professorship at Giessen to succeed Professor Koch at Berlin, was one of Koch's earliest assistants, and accompanied him on the cholera expedition of 1883-84.



THE NEWLY-ELECTED PRESIDENT OF THE R.C.S.I.

MR. ARTHUR CHANCE, F.R.C.S.I., Vice-President, who succeeds Sir Lambert Ormsby, President of the Royal College of Surgeons, Ireland, has filled the posts of Surgeon-in-Ordinary to the Lord Lieutenant of Ireland and Examiner in Surgery to the College. He is Surgeon to the Mater Misericordiae and to the Dublin Orthopaedic Hospitals, and consulting surgeon to the St. Michael's Hospital. Our portrait is from a photograph by F. P. D'Arcy, Dublin.

### Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

#### SCOTLAND.

FIRE IN THE EDINBURGH ROYAL INFIRMARY.—Considerable damage was done in the Pathological Department of the Infirmary by a fire which occurred on July 4th, shortly after midday. Dr. Shennan, the pathologist, was engaged on a post-mortem examination at the time, and the alarm was given by molten lead dropping through the ceiling of the theatre, which was occupied by students. The room above, used as a pathological laboratory, was discovered to be in flames, and, notwithstanding the efforts of the Infirmary brigade and the city fire brigade, the whole upper storey of the building was gutted, damage to the extent of about £1,000 being caused, besides the loss of much valuable pathological material. The fire is believed to have been caused by an electric wire fusing, and the only reason why it assumed such serious dimensions was an inadequate water supply. This was a matter of strong complaint at the usual managers' meeting held in the afternoon, and it was decided to communicate with the Water Trust on the matter. The Pathological Department is, of course, quite isolated from the rest of the hospital, but if a fire took place in the main building the defective water supply might easily have more serious consequences than in this instance. The laboratory of the Royal College of Physicians has been placed at the disposal of the Infirmary pending the restoration of their own.

PRESENTATION TO PROFESSOR HEPBURN, CARDIFF.—The eighteenth annual dinner of the Edinburgh Company R.A.M.C. Volunteers was made the occasion of a presentation to the former commanding officer, Surgeon-Major Hepburn, who, during so many years of his work

in Edinburgh, took the deepest interest in the welfare of the corps. The presentation took the form of a gold watch, and was subscribed for by former members of the company all over the world. In a felicitous speech, Lieutenant Waterston, the commanding officer, expressed the warm feelings of regard which all the past and present members of the company felt for Professor Hepburn. Between seventy and eighty members of the company were present, among the guests being Colonel Hughes, D.S.O., R.A.M.C., the P.M.O. Scottish District, Major Scott, R.A.M.C., and Mr. C. W. Cathcart, the first commanding officer of the Edinburgh Company.

### Correspondence.

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

#### SANITARY AND BUILDING BYE-LAWS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent, "Modernus," must be of a particularly sanguine temperament if, with any knowledge of the Local Government Board, its bye-laws, and their administration by local authorities, he imagines the refinements of sanitation he suggests are likely ever to be adopted and put in force. Very few municipalities strictly enforce the present model bye-laws, which they almost all adopt; and where the council, urban or rural, as often happens, is composed of or dominated by mean, ignorant, and vulgar men—small tradesmen and jerry builders—they do not enforce any which seem irksome to their interests or those of their friends. Medical officers of health are here, as in so many other directions, practically powerless. They may point out quietly to the sanitary committee the iniquity of disregarding essential measures for the prevention of disease; but they are the servants of the authority, and it is as much as their place is worth to raise any public protest against even the most glaring of abuses. The great bulk of the public know little and seem to care less about local government. There exists almost complete lack of local patriotism in this regard throughout the country. Men of position and intellect as a rule refuse to take any part in local government. They will not offer themselves as candidates for membership of councils, nor take any active steps in putting fit men on. Democratic institutions cannot be administered to full advantage unless all intelligent citizens take a due interest in their working. The present apathy forms a danger to the nation. Even in London not more than 40 per cent. of the burgesses could be induced to vote at the last County Council election. There exists in England very little of the municipal corruption such as disgraces the United States; but a very great part of the legislation which, if energetically enforced, would bring the country into a position relatively of vast sanitary improvement is now either altogether neglected or only carried out in a partial and ineffective fashion.

I am, Sir, yours truly,

July 7th, 1904.

M. O. H.

#### LUNACY—A PRACTICAL DEFINITION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Although I have not the advantage of your correspondent "R. L." in legal training, he will excuse me saying that his letter scarcely touches mine except when he refers to my having incidentally adopted the perhaps not very graceful expression of "a bullying counsel;" and I cannot, moreover, quite agree with him if he thinks the millennium has quite arrived amongst gentlemen at the bar, as it is proverbially whispered that when a counsel has no leg to stand upon he resorts to the practice of "bullying" his opponent.

Your correspondent in his letter, June 22nd, calls attention to what appears to me the indefiniteness of insanity and quotes the evidence of Dr. Distin and his vague opinion expressed in court, viz., "the man was a

criminal lunatic, but that it was one of those cases where they could not certify insanity"; and in my reply I supplemented this by reciting a case of a medical witness who informed a Counsel that it would take two days (or to that effect) to formulate a definition, so on the face of all this I ventured to suggest "a morbid condition of mind requiring supervision" as a likely definition. Your correspondent does not, I note, criticize my definition, neither does he offer one of his own; but on the other hand, strange to say, he appears now neither to acquiesce with Dr. Distin because he adds—"In such a case as the Archdeacon's brother a lawyer would, perhaps, take the view that other people can be left to take care of themselves till crime has brought the lunatic within reach of the law." Surely, "R. L." would not endorse the view of leaving, say, a homicidal or suicidal patient, or tending that way, to take care of himself till a crime was committed; if not, what relevance is there in making this remark?

Now, sir, I apprehend that the law takes cognisance of insanity in its criminal and civil code, and constitutes itself the guardian of an insane person *only in one sense*, and that is so far as the liberty or freedom of action of any individual is concerned; so that to conceive and differentiate any practical definition of insanity, we must take care as far as possible to conform to and limit such definition to the ideas which the law entertains on the subject—i.e., liberty.

In a letter in your columns a short time ago I defined insanity in its broadest, logical and most comprehensive area as "a greater or less deviation from reason"; but it is obvious that such a wide definition would embrace all minds and delusions the outcome of feeble judgment and defective reasoning powers which, although these weaknesses might render such minds unfavourable competitors in the battle of life, nevertheless would be insufficient to convince a jury of the necessity for legal supervision, neither do we wish to convince them in such cases. On the other hand we have to show, on a lunacy certificate supplied to us by law, from our own observation and from hearsay evidence, *that degree* of "morbid condition of mind requiring supervision" and to substantiate such certificate in a law court if need be. I know not what your correspondent thinks of my definition, and it is open to anyone to improve upon it or furnish a better. However, it is certain that when a medical witness proffers evidence on insanity in a court and he is asked the abstruse question, "What is insanity?" he should be armed to the teeth with some answer, however simple, which may appeal to and satisfy the commonsense and intelligence of an English jury.

I am, sir, your truly,

Brighton, July 7th, 1904.

CLEMENT H. SERS.

#### THE MIDWIVES' INSTITUTE.

WE have received from the secretary of the Midwives' Institute, and also from Messrs. Brown, Ringrose, and Lightbody, letters repeating the denial of the appearance on the agenda paper of the former body of a paper called "Malthusianism, or Tired Ovaries." The second letter contains the following paragraphs:—  
"Our clients, the Incorporated Midwives' Institute, have consulted us with regard to the statements contained in the leading article headed 'The Lifting of the Veil,' in your issue of June 8th last, and in your comment at the foot of the Institute's secretary's letter to you as in your issue of June 29th last.

"The statements contained in the leading article of which the Institute complain have been already clearly indicated in their secretary's letter to you above referred to, and in her further letter to you of June 30th last, of which we are instructed you have taken no notice. Further, the secretary's letters have already amply repudiated as untrue the statements contained in the article in question. We therefore consider it unnecessary to explain or repudiate same further.

"The further statements contained in your comment above referred to, viz., that the writer of the leading article saw an agenda paper purporting to come from the Midwives' Institute containing the title of the

paper as given in the leading article, and stating that such paper was down for the next meeting of that Institute, however, gives our clients still further cause for complaint, as it is, we are instructed, absolutely untrue that any such paper was ever put down on any agenda of the Incorporated Midwives' Institute.

"It would appear, however, from a record of the proceedings of the Midwives' Society (of Manchester?) for December 2nd, 1897, that a paper with the title referred to in the leading article was then read before that Society. Our clients cannot believe that either the writer of the leading article or you yourself could through ignorance thus confuse the name or proceedings of The Incorporated Midwives' Institute of London with those of The Midwives' Society of Manchester, the latter being, we are instructed, a small society established some years ago at Manchester (whether now existing our clients are unaware); but they very strongly object to their Institution being confused in any way with the Society referred to."

We, of course, accept this explicit disclaimer, but we would point out that a similar doubt to that which makes our correspondents add (of Manchester?) to the title of the Midwives' Society is possibly responsible for the confusion which is stated to have occurred in our case between the "Midwives' Institute" and the "Midwives' Society." The agenda paper in question was, to our knowledge, sent to a nurse, as an inducement and with an invitation to join the Midwives' Institute or Society. We were distinctly under the impression that the invitation came from the former body, but as one society would be most unlikely to enclose the agenda paper of another unless there was a very close connection between the two, we have pleasure in accepting our correspondents' repudiation. Will they in return inform us if the "Incorporated Midwives' Institute" was absorbed or is in any way connected to or affiliated with the "Midwives' Society?"—ED.

## Obituary.

### MR. JOHN BIRKETT.

WE regret to announce the death of Mr. John Birkett, at his residence, Sussex Gardens, Hyde Park, London, on the 6th inst., in his ninetieth year. He was educated at Guy's Hospital, and in Paris, and admitted a member of the Royal College of Surgeons, England, in 1837, elected an honorary Fellow in 1844, and Jacksonian prize winner for 1848. He was surgeon and lecturer on surgery at Guy's Hospital and subsequently consulting surgeon; examiner in surgery to the Royal College of Physicians, London, Hunterian Professor of Surgery and Pathology, and examiner in surgery to the University of London, and for many years Government Inspector of Anatomy in England and Wales. Mr. Birkett was also president of the Royal College of Surgeons, England, a Fellow of the Royal Medical and Chirurgical Society, and of the Medical Society of London.

## Medical News.

### Prize Day at Guy's Hospital.

THE distribution of prizes to the successful students of the Guy's Hospital Medical School took place on July 6th, at the Hospital. The prizes were presented by Lord Goschen and among the medallists and prizemen were S. J. Darke, who gained the £100 open scholarship in Arts. H. A. Sanford was awarded the £150 open scholarship in science, and C. W. Greene took the £50 scholarship for university students. Lord Goschen in his address expressed admiration at the progress made in scientific research, and pointed out that further research and study were required to open up the Hinterland of the unknown in medical science. All students, however, could not be scientific investigators, the country must have general practitioners as well. He warned his hearers that the medical student from his earliest education and work necessarily dealt with facts and the material aspects

of nature, so that he had reason to guard himself against materialistic influences. There was another danger, and that was from the moral point of view. The close and constant contact with the darker side of human nature—with sin, crime, and disease—might lead a medical man to become pessimistic, but he urged them to hold to their faith in human nature and to hold high the standard of honesty. The garden party held afterwards in the Hospital gardens was attended by over 3,000 people, and the gathering proved a brilliant success.

### The North-East London Clinical Society.

THE annual dinner of the above Society was held on Friday, July 8th, 1904, at the Great Eastern Hotel, Liverpool Street. The President, Dr. J. W. Hunt, occupied the Chair. Among those present were Dr. F. de Havilland Hall, Dr. A. T. Davies, Mr. Langton, and Mr. L. H. G. Kerr. In replying to the toast of "The Society," Dr. R. Murray Leslie, the president-elect for the ensuing session, remarked that the North-East London Clinical Society differed in many respects from other London medical societies, in that the meetings were held during the afternoons, which had been found to be the most convenient time for the great majority of busy practitioners. He also referred to the excellence of the clinical material, and to the free discussions which characterised the meetings. He hoped that members would avail themselves of the opportunities which were extended to them of attending the lectures to be delivered at the North-East London Post-Graduate College, for issuing which invitation he had the authority of the Dean, Dr. A. J. Whiting. A good musical programme was provided, and altogether the members, together with their lady friends, spent a most enjoyable evening.

### The Oxygen Hospital.

H.R.H. PRINCESS LOUISE, as patron of this institution, attended the annual meeting last week in Fitzroy Square, at which many members of the committee and other supporters were present. Mr. Burdett-Coutts occupied the chair, and urged the great need of further financial support. A sum of between £700 and £800 was, he said, needed for immediate requirements, and upon a very slender income the hospital was fulfilling a really valuable work of scientific and pathological research. A vote of thanks to Her Royal Highness was moved by Mr. J. B. Lonsdale, M.P., and seconded by Dr. Stoker, who said that he first derived the idea of using pure oxygen from the Zulus, who exposed their wounds or injuries to the fresh air and sunshine of the hills and uplands with frequent gratifying results.

### Royal College of Surgeons in Ireland.—Prize List, Summer Session, 1904.

*Barker Anatomical Prize.*—£31 10s., C. Cooper.  
*Mayne Scholarship.*—£15, A. N. Crawford.  
*Carmichael Scholarship.*—£15, J. Prendiville.  
*Gold and Silver Medals in Operative Surgery.*—Gold: J. S. Dunne. Silver: P. D. Sullivan and J. C. Murphy (equal).  
*Stoney Memorial Gold Medal in Anatomy.*—J. Prendiville.

*Practical Histology.*—H. C. Carden, first prize (£2) and medal; D. Adams, second prize (£1) and certificate.

*Practical Chemistry.*—R. H. F. Taaffe, first prize (£2) and medal; F. C. Warren, second prize (£1) and certificate.

*Public Health and Forensic Medicine.*—M. Cohen, first prize (£2) and medal; T. H. Massey, second prize (£1) and certificate.

*Materia Medica.*—F. C. Warren, first prize (£2) and medal; J. B. Kelly, second prize (£1) and certificate.

*Biology.*—J. C. S. Day, first prize (£2) and medal; T. C. Boyd and H. W. White (equal), second prize (£1) and certificate.

The winter session will commence in October. Prospectus now ready.

### Doctor's Death from Plague.

NEWS of the death of Dr. Noel Unsworth, Cairo, is to hand. He took an active part in combatting the cholera epidemic of 1902, and had subsequently been engaged on plague duty in the delta for the Sanitary Department. He contracted bubonic plague three days before, and died last Sunday morning.



## 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.

### TRIALS OF MEDICAL MEN.

The following, according to the *Captain*, are some of the sweets of a doctor's life:—If he goes to Church regularly, it is because he has nothing else to do; if he does not go, it is because he has no respect for the Sabbath or religion. If he has a good carriage, he is extravagant; if he uses a poor one, on the score of economy, he is deficient in necessary pride. If he visits his patients every day, it is to run up a bill; if he does not, it is unjustifiable negligence. If he says anything about religion, he is a hypocrite; if he does not, he is an infidel. If he uses any of the popular remedies of the day, he indulges the whims and prejudices of the people to fill his pockets; if he does not use them, it is from professional selfishness. If he is in the habit of having counsel often, it is because he knows nothing; if he objects to have it, on the ground that he understands his own business, he is afraid of exposing his ignorance to his superiors. If his horse is fat, it is because he has nothing to do; if it is lean, it is because it does not get enough to eat. If he drives fast it is to make the people think somebody is very ill; if he drives slow, he takes no interest in the welfare of his patients. Finally, if he gets paid for one half of his services, he has the reputation of being a great doctor. "M. D."

A **CARDITOR** suing a doctor in the Clerkenwell County Court mentioned that the debt was "for a pair of trousers to bury the doctor's wife in." Visibly startled, the judge exclaimed, "Surely burial reform has not come to that yet."

### AN OFT REPEATED EPIGRAM.

The following epigram was quoted by Dr. Hutchinson in a debate on the Licensing Bill in the House of Commons. It can hardly be said to be *ad rem* to the discussion, and was moreover incorrectly reported. It should run thus:—

God and the Doctor we alike adore,  
But only when in danger, not before;  
The danger past, both are alike requir'd,  
God is forgotten, and the Doctor slighted."

**EDINBURGH STUDENT**.—We have seen no announcement of a new edition of the book referred to and think another is unlikely just yet.

### THE CENTRAL MIDWIVES' BOARD.

We understand that the resolution at the last meeting reported in our issue for July 8th that "registered members of the medical profession only be eligible for appointment as examiners under the Central Midwives' Board" was not carried: Dr. Japp Sinclair, Dr. Ward Cousins, and Mr. Parker Young voting for; and Dr. Cullingworth, Miss Wilson, Miss Oldham, and Miss Paget against it.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 13th.

**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. L. Chestle: Clinicque. (Surgical.) 5.15 p.m. Dr. S. Taylor: Hemoptysis and its Treatment.

THURSDAY, JULY 14th.

**THE BRITISH GYNECOLOGICAL SOCIETY** (20 Hanover Square, W.).—Specimens, Mr. Christopher Martin: (1) Bone Crochet Hook removed from the Abdominal Cavity. (2) Two specimens showing Arrested Development of the Uterus. Dr. Macnaughton-Jones: (1) Specimen illustrating the Relation of Hydrosalpinx to Accessory Fallopian Tubes, with notes. (2) Specimens of Adnexal Tumours bearing on the question of Hysterectomy. (3) Adnexal Sections with the Epidiascope. Mr. Bowreman Jessett: (1) Removal of Large Fibro-Cystic Tumours by Abdominal Hysterectomy, followed by gangrene of the Right Leg. (2) Uterus removed by Abdominal Hysterectomy with large Sub-mucous polyp Intestinal Fibroid, and Sub-peritoneal Fibroids. Dr. Jervois Aarons: A New Uterine Mop.

**NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM** (11 Chandos Street, Cavendish Square, W.).—8 p.m. Clinical Meeting. Exhibition of Cases of Myelopathic Muscular Atrophy.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinicque. (Surgical.) 5.15 p.m. Dr. S. Taylor: Hemoptysis and its Treatment.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Dr. F. Price: Aortic stenosis (illustrated by cases). (Post Graduate Course.)

FRIDAY, JULY 15th.

**SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN** (Victoria Hall, Hotel Cecil).—6.30 p.m. Mr. R. C. Lucas: The Hereditary Bias and Early Environment in their Relation to the Disease and Defects of Children. (Wightman Lecture.)

## Vacancies.

- Borough Asylum, Canterbury**.—Assistant Medical Officer.—Salary £140 per annum, with furnished quarters, board, and laundry. Applications to the Medical Superintendent.
- Ayr District Asylum**.—Assistant Medical Officer.—Salary £120 with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.
- City of Leeds—Infectious Diseases Hospitals**.—Second Assistant Resident Medical Officer. Salary £120 a year, with board, lodging, and washing. Applications to the Medical Superintendent, City Hospitals, Beacroft, Leeds.
- Brecon and Radnor Asylum, Talgarth, R.S.O.**—Assistant Medical Officer. Salary £140 per annum with furnished apartments, board, attendance, and laundry. Applications to the Medical Superintendent.
- The Royal National Hospital for Consumption and Diseases of the Chest, Ventnor**.—Senior Resident Medical Officer. Salary £200 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London.
- Royal National Hospital for Consumption and Diseases of the Chest, Ventnor**.—Two Assistant Resident Medical Officers. Salary £100 per annum, with board and lodging in the Hospital. Applications to the Secretary, 34 Craven Street, Charing Cross, London, W.C.
- Hereford County and City Asylum**.—Senior Assistant Medical Officer. Salary £150 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent.
- Southwark Union, London**.—Second Assistant Medical Officer, Infirmary, East Dulwich Grove S.E. Salary £100 per annum, with board, lodging, and washing. Applications to Howard C. Jones, Clerk, Union Offices, John Street West, Blackfriars Road, S.E.
- Dorset County Hospital, Dorchester**.—House Surgeon.—Salary £100 per annum. Applications to W. E. Groves, Valetta, Icenway.

## Appointments.

- BLAIR, CHARLES, M.D., Durh.**, F.R.C.S. Eng., Surgeon to the Western Ophthalmic Hospital, London.
- CLAYTON-GREENE, W. H.**, M.B., B.C. Cantab., F.R.C.S. Eng., Supernumerary Surgeon in Charge of Out-patients to St. Mary's Hospital, Paddington.
- COURTENAY, F. W. E.**, L.R.C.P., L.R.C.S., Medical Referee to the Empire Guarantee and Insurance Corporation, Limited.
- EDMONDS, EDGAR FLETCHER, M.B.**, B.S. Durh., Assistant House Surgeon to the Rotherham Hospital and Dispensary.
- EMMERSON, A. T.**, M.D. Toronto, Clinical Assistant to the Chelsea Hospital for Women.
- JOHNSON, H. MULREA, M.B.**, B.Ch., Chief Demonstrator of Anatomy in Trinity College, Dublin.
- MACKENZIE, MARION E.**, M.B., Ch.B. Edin., House Surgeon to the East End Branch of the Children's Hospital, Sheffield.
- NICHOLLS, T. J.**, L.R.C.P., and S.I. House Surgeon to Mercer's Hospital, Dublin, *vis à* Dr. Willington resigned.
- PALMER, FREDERICK S.**, M.D., M.R.C.P., Assistant Physician to the West End Hospital for Diseases of the Nervous System.
- PATER, ALASTAIR GORDON, M.B.**, Ch.B. Aberd., Senior House Surgeon to the Great Northern Central Hospital.
- ROWLETTE, ROBERT JAMES, B.A.**, M.D. Dubl., Anaesthetist to the Incorporated Dental Hospital of Ireland.
- SASS, WILFRID, M.R.C.S.**, L.R.C.P. Lond., Assistant Anaesthetist to the Cancer Hospital, Brompton, S.W.
- STEHEEN, W.**, B.A., M.B. Toronto, Clinical Assistant to the Chelsea Hospital for Women.

## Births.

- DICKSON**.—On July 5th, at The Lodge, Wye House, Buxton, the wife of Graeme Dickson, L.R.C.P., &c., of a daughter.
- SEALE**.—On May 28th, at Oakfield, Ceres, Cape Colony, the wife of Edward A. Seale, M.D., of a daughter.

## Marriages.

- CLARKE-O'FARRELL**.—On July 6th, at St. Bartholomew's Church, Dublin, Major J. L. J. Clarke, East Yorkshire Regt., D.A.A.G., 3rd Army Corps, only son of Lt.-Colonel Alfred Clarke, M.D., Royal Military College, Camberley, to Lillian, only daughter of Sir George and Lady O'Farrell, of 19 Fitzwilliam Square.
- GODDARD-ROGERS**.—On July 7th, at the Parish Church, Watford, Claud Francis, the fourth son of the late Eugene Goddard, M.D., of Highbury, and Mrs. Goddard, of Fernbank, Sudbury, Harrow, to Annie Evelyn, the eldest daughter of James Rogers, of Watford.
- HARTLEY-PERRIN**.—On July 6th, at the Parish Church, Harrow-on-the-Hill, John Dawson Hartley, F.R.C.S., of 39 The Terrace, Gravesend, elder son of Stephen Hartley, High Street, Harrow, to Margaret Young, second daughter of William Perrin, of Harrow.
- HELSDON-PREEDY**.—On July 6th, at St. Peter's Goodworth, Clatford, Charles Victor Helsdon, M.R.C.S.E., of Penton, Mewsey, Hants, to Catherine, younger daughter of the late John Preedy.
- PATCH-SMITH**.—On July 5th at Esher Parish Church, Burnet Graham Patch, R.A.M.C., youngest son of Colonel R. Patch, C.B., Indian Army, of Fersfield Newton Abbot, to Edith, younger daughter of E. G. Warren Smith, of Esher.

## Deaths.

- BIRKETT**.—On July 6th, at 1, Sussex Gardens, Hyde Park, John Birkett, F.R.C.S., in his 90th year.
- CRAIGIE**.—At Blagdon, near Bristol, Francis Louis Craigie, the fourth son of the late Dr. Craigie, and Mrs. Jane Craigie, of Holyoake.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, JULY 20, 1904.

No. 3.

## Original Communications.

### THE DIMINISHING BIRTH-RATE.

By DAVID WALSH, M.D. Edin.,

Senior Physician, Western Skin Hospital, London, W., &c.

#### PART II.

*Assumption III: That a falling birth-rate necessarily indicates a failure in national prosperity.*—Dr. Taylor quotes as his keynote Ruskin's dictum "that the final outcome and consummation of all wealth is the producing as many as possible full-breathed, bright-eyed and happy-hearted human creatures." The whole trend of his article, however, shows that he is governed by the underlying fallacy that a steadily increasing birth-rate is, by sheer force of numbers alone, necessarily a sign of national prosperity. In young or undeveloped countries, that may be the case. In all countries, however, there is a limit of supportable population, and when that point is reached disaster must follow.

Following a method that is now classical, let us take the case of an imaginary island, of an area, say, of twenty square miles, which by its natural resources can maintain a population of two thousand souls. It is obvious that if the population exceed that maximum, general want and misery will result, until disease and starvation reduce the numbers to two thousand or less. But suppose that ships from other lands visit our island, and enable its inhabitants to exchange their surplus granite and other products for the foreigners' foodstuff, then a fresh lease of life will be granted them. Some of the surplus population, moreover, will be able to relieve the pressure at home by emigration. Still, twenty square miles will not support an indefinite number of people, however great their natural resources and their trading facilities. When the population reaches the second or artificially raised maximum, say, of twenty thousand, another disastrous readjustment must take place, and the inhabitants will have either to die down again or to emigrate. To introduce children into an over-crowded society of that kind would be to subject them to misery and death, to say nothing of the injury inflicted upon the already existing population. Yet, if we agree with Dr. Taylor that it is wrong to place a check upon lawful procreation, the parents of that community would be morally constrained to go on rearing children under conditions of food and air starvation. The starveling generation thus produced would be short-lived and riddled with insanity, crime, alcoholism, and other signs of degeneracy.

Let us now apply the test of the supportable limit of population to the two statements of Ruskin, which were accepted as axioms by Dr. Taylor. The propositions run thus: First, "There is no wealth but life. That country is richest which nourishes the greatest number of noble and happy human beings"; and, again, "the final outcome and consummation of all wealth is in the producing as many as possible full-

breathed, bright-eyed and happy-hearted human creatures." From these axioms we deduce there are three tests of the wealth of a community—the growth in numbers of inhabitants, their health and their happiness. Numbers alone without the correlations of health and happiness are no indication of wealth, and that country which propagates an increasing quantity of deformed, imbecile and immoral offspring would be worse off than another country which produced a smaller number of healthy and happy children. If Dr. Taylor, therefore, quotes Ruskin in proof of the unqualified assumption that the wealth of a nation consists in the mere number of children it produces, he seems to the writer to be starting on a false premise. Quality, according to Ruskin, is at least as essential as quantity. His axioms, when applied to poor and over-crowded populations, absolutely discountenance the unlimited procreation of children, inasmuch as slum children cannot be "full-breathed, healthy and happy" and, in point of fact, they are as a class rickety, pale, unwholesome and vicious. The wealth of a country, tested numerically, must be further qualified by its ability to maintain the fresh generation at a standard of well-being in body and in mind at least equal to its own. Dr. Taylor has advanced the fallacy of partial quotation. Let us now add the rest of the passage from Ruskin as to the "full-breathed, bright-eyed and happy-hearted human creatures." "Our modern wealth," he writes, "I think, has rather a tendency the other way, most political economists appearing to consider multitudes of human creatures not conducive to wealth, or, at best, conducive to it only by remaining in a dim-eyed and narrow-chested state of being." Yet if the poorer classes are to go on multiplying children, according to Dr. Taylor's theory of what is their moral duty, they can for the most part swell the population only by degenerate and short-lived offspring.

The production of mere numbers of offspring, then, apart from their quality and destiny, is no true test of the inherent prosperity of a nation. Great reproductive activity is often, as in consumptives, a sign of degeneracy. The young generation, to satisfy the sanitarian and the economist, must be healthy and long-lived. To thrust feeble children under conditions of poverty into an already over-crowded community is to commit an act of selfish imprudence, the consequences of which must react on the parents in a manner not less disastrous than the evils attributed by Dr. Taylor to the artificial prevention. The ultimate population test is thus expressed by Ruskin:—(a) "The radical question is, not how much habitable land is in the world, but how many human beings ought to be maintained on a given space of habitable land." Suppose parents to be living in a certain spot that has reached its limits of supportable population. Can it be seriously maintained that the unlimited production of children would still be a moral obligation? Yet that is Dr. Taylor's proposition, unqualified by any conditions as to class in society, income, social circumstances, or facts of environment. If I interpret his

(a) "Ad Valorem." John Ruskin .1882, P. 162.

meaning aright, the plain bounden duty of all married persons, whether dwelling in rich houses or in sordid hovels, is to beget as many children as possible.

Beyond a doubt, poverty shortens life both for parents and for children. The remarkable statistics of Ansell show that the child of rich parents has a far greater chance of survival to adult, middle, and old age than the child of the poor. Dr. Drysdale, again, has shown that poverty is the main cause of premature death in old countries, such as those of Europe. (a) But the great proportion of increase now takes place among the poor, whose children are foredoomed to pay a terrible toll of suffering and premature death. Can a nation be really the richer for so vast a multiplication of feeble and shortened lives?

In a young country, such as a sparsely-populated colony, the mere multiplication of numbers may be a just measure of its prosperity. In an old and over-populated country it may be the reverse. At the same time in the more densely populated country the State is able to employ part of its surplus as soldiers and sailors, and capital to trade on the necessities of the struggling workers by grinding down wages to the lowest level.

*Assumption IV (or unsupported conclusion): That preventive practices are injurious to the moral and physical well-being of parents adopting them, as well as to the non-prevented children of such marriages.*

Doubtless now and then some of the pathological accidents mentioned by Dr. Taylor follow the use of preventive measures. They cannot, however, be common, and Dr. Taylor must forgive us for not attaching great weight to the two or three instances of acute mischief he is able to recall from his extensive experience. A certain number of persons are killed every year in crossing the street, apparently in obedience to some obscure law of average fatality that is inseparable from the majority of human actions and pursuits. To bring forward these exceptions would not be to establish any general causative relation between crossing the street and sudden death. Yet that is the kind of argument considered good enough by Dr. Taylor when he condemns preventive methods as physically injurious, because he has known one or two cases of peritonitis, and one of purulent infection follow their use. Nor can we accept more seriously his statements as to mischievous results of a chronic nature. Neurasthenia is the only specific instance he advances, and he ascribes that condition to "sexual onanism" and absence of the male element from the female economy. It is well known that neurasthenia may follow any excess, among the married or the unmarried, among those who desire conception or those who prevent it; but it is at least as common in the woman who has had many children as in any other individual or class of society. But if the object of all should be to raise up as many children as possible, continence—apart from its disciplinary effect—must be bad too, for it robs the community of possible accession to its ranks, and the State that demands children will bear an equal grudge against the continent and against the sexual onanist, for both conspire to prevent its heritage. The increase of juvenile crime, again, cannot reasonably be assigned to any limitation of the size of families. The only child, or the child of a small family, is always better looked after in mind, body and estate than the child who has eight or ten or more brothers and sisters, for reasons that are obvious. Besides, the overwhelming proportion of criminals is drawn from the class in which the limitation of families is least practised. Lastly, I ask Dr. Taylor if the vast majority of female troubles that come under his professional care, both in private and more especially in hospital practice, is not far more often due to multiple than to restricted child-bearing? From my point of view, an enormous proportion of the avoidable disease, insanity and crime that constitutes so great a blot upon our modern civilisation may be traced to the unrestricted multiplication of the children of the poor.

(a) "Population Question." E. C. Drysdale, M.D. Medical Society of London, October 27th, 1879.

Dr. Taylor has courageously attacked a delicate subject, but to my mind he has missed the real significance of the fall in the birth-rate during the last half century or so. He is a man of eminence in his profession, and of unquestioned candour and honesty of purpose. For all that, it is impossible to accept his views upon this most important matter without careful critical examination. It would be little short of disastrous were his particular views permitted to go out into the world unchallenged as those accepted generally by the medical profession.

One of the first questions that suggests itself in approaching this subject is whether the United Kingdom may not have reached its limit of supportable population. The growth of juvenile crime, of insanity, and of pauperism, and the increasing numbers of the unemployed working classes, seem to show that under existing social conditions a further increase in children becomes a positive disadvantage. The poor are now the prolific classes of the community, that is to say, the very persons who bring their offspring without stint into an environment that fosters pauperism and the other evils spoken of. The existence of so great a mass of avoidable misery and waste of life to my mind proves incontestably that under existing social conditions the supportable limit of population has been reached so far as the poor of our country are concerned. True, that limit may at any time be enlarged so as to admit of a happier existence for a greater number of the population. Some small relief may be effected by emigration, but after all said and done, that is only a temporary measure, which must come to an end sooner or later. The sound remedy will possibly or probably be found in laws that lead to greater equality in the distribution of wealth and of opportunity to the individual citizen.

Ruskin's view of the three remedies commonly suggested by the economist for over-population is much to the point. (a) He writes:—"These three are, in brief, colonisation; bringing in of waste lands; or discouragement of marriage. The first and second of these expedients merely evade or delay the question. It will, indeed, be long before the world has been all colonised, and its deserts all brought under cultivation. But the radical question is, not how much habitable land is in the world, but how many beings ought to be maintained on a given space of habitable land." The third expedient—discouragement of marriage—is not discussed by Ruskin. His answer, however, may be plainly inferred from his general views on the necessity of proper conditions of environment for every citizen. When Ruskin first published his book methods of prevention had not become widely known or advocated, or he might possibly have added a fourth expedient.

#### WHAT ARE THE INFLUENCES THAT GOVERN THE INCREASE OR DECREASE OF A HUMAN POPULATION?

In the lower form of animal life limitation of numbers is regulated by laws of which we know little or nothing. Darwin has somewhere pointed out that wood-lice multiply at such a rate that a single pair, if left alone, would in a comparatively short time be able to cover a continent. But in no locality do wood-lice obtain a preponderating numerical superiority. The herring, in common with most fishes, produces a countless progeny, but the herring tribe remains a fairly constant inhabitant of the sea. So, too, with rabbits and mice and other mammals. The rule in Nature appears to be that each species should produce a progeny vastly in excess of the actual needs of the case. Further, the limit of numbers seems to be fixed in some ill-defined but remorseless way. Why should not similar laws apply to mankind? At the present moment, as in past ages, he reproduces his kind in numbers vastly in excess of those that actually survive to the next generation. Lastly, man, from his special endowment of brain, may impose an artificial limitation upon child-bearing, and by this very intellectual limitation may

(a) "Unto this Last." By John Ruskin. Third edition. 1882. London. Pp. 102.

be constituting himself an unconscious instrument of evolution.

The population of England and Wales has taken about fifty-eight years to double itself. By the *law of population*, the latter increases in regular geometrical progression when the births exceed the deaths, and the ratio of the births and of the deaths remains constant. Were the population of England and Wales to go on doubling twice in 116 years, the figures would soon become stupendous. Farr, (a) dealing with this point, quoted a passage from an early edition of Malthus' "Political Economy." "If any person will take the trouble to make the calculation, he will see that, if the necessaries of life could be obtained without limit, and the number of people could be doubled every twenty-five years, the population which might have been produced from a single pair since the Christian era would have been sufficient, not only to fill the earth quite full of people, so that four should stand upon every square yard, but to fill all the planets of our solar system in the same way, and not only them, but all the planets revolving round the stars which are visible to the naked eye, supposing each of them to be a sun, and to have as many planets belonging to it as our sun has."

That preventive methods are increasingly practised among the better-to-do classes must be admitted. Some figures bearing on the relation between social position and fertility were given by Dr. J. Bertillon, (b) quoted by Dr. Newsholme at the meeting of the International Statistical Institute at St. Petersburg, September, 1897. The statistics relate to the births per 1,000 women, æt. 15 to 50, per annum, in different quarters of the undernoted cities.

Classification.	Paris.	Berlin.	Vienna.	London.
Very poor quarters ..	108	157	200	147
Poor quarters ..	95	129	164	140
Comfortable quarters	72	114	155	107
Very comfortable q'ters	65	96	153	107
Rich quarters ..	53	63	107	87
Very rich quarters ..	34	47	71	63
Average ..	71	101	141	109

The stress of human suffering from increase of population beyond readily supportable limits must, of necessity, fall mainly upon the poorer classes. It demands a considerable exercise of faith to ask such poverty-stricken families to accept the teaching that the multiplication of children is one of man's highest moral obligations. Dr. Drysdale (c) speaks plainly enough on this last point as follows:—

"My argument is, then, as Sir Henry Thompson expresses it, that our farm is over-stocked with human animals, and that this is the only real cause of the permanent death-rate in our cities; and I contend that so long as the people of Great Britain continue to add to the population in the ratio of 362,923, as was done in 1877, or to have an annual birth-rate of 36 per 1,000, it is useless to expect anything from drainage schemes or the other expedients of public hygiene. Slums will always exist as long as people have such low wages that they cannot afford house-room enough for the over-numerous offspring they engender, a species of improvidence so conspicuous as yet among the poorer classes in the United Kingdom."

The stress of many children falls with terrible severity upon the mother where the family income is small. Take the case of the wife of the struggling clerk, the labourer whose work is inconstant, the poor curate, or the medical man in small practice, in a word, of any family belonging to the not-rich class of society where one child might be brought up well enough. Child upon child has to be fed, cared for, clothed, and educated, until the life of the mother is that of a slave, to say nothing of the tax of frequent maternity upon a body that is undermined with toil, privation, anxiety and short commons. The curate's lot in life is to

inculcate morals into the mind of his fellow-men. Can he, when a poor man, justify his position in multiplying his family indefinitely? Should he not either practise continence or decline the responsibilities of marriage, rather than drag a refined woman into a position of drudgery, broken health, and shortened life, while at the same time his numerous progeny are curtailed in necessaries of life, in comforts, and in education, so that in many cases private means must be eked out by the charity of strangers? The patient self-sacrifice of the mother of all ages, past and present, is written in blood on the pages of the world's history. It would be easy to draw a lurid picture of the difference between the many and the few children so far as the mother is concerned. Ansell, an acute observer, partially recognises the situation in the following suggestive passage:—

"In the upper and professional classes," he writes, "it is upon the men that the wearing toil and anxieties of life chiefly press, the women enjoying a comparative exemption from them. At the present age, when so many are striving to be foremost in the race of life, the husband is frequently, or it may be constantly, engaged in an arduous struggle to maintain or improve his position, and, whether successful or unsuccessful he, in too many instances, injures his health in the effort. Unless, however, he be exceptionally unfortunate, and at the same time have no friends to fall back upon, his wife and family will probably still be sufficiently supplied with the bare physical necessaries for healthy existence. With the labouring classes the case is very different. Among them the mental anxieties of obtaining a livelihood are rarely great enough to produce injurious results, but if the husband's wages are insufficient, the consequent physical privations tell upon the health of his family, his wife included, at least as much as, and probably more than, upon his own." (a)

But to review: We find a fall in the birth-rate—not as great as Dr. Taylor shows, nor confined to the married population, as he imagines—but still a fall, and we find that this fall is great among the upper classes of society, and probably affects to a certain extent the lower classes also. Now, what does this show? We reply that in this great competition the necessary limitation of future generations is showing itself most among the educated classes—a kind of intellectual limitation. This may be a matter of regret, especially if one adopts with Dr. Taylor the Spencerian doctrine that inherited qualities are transmissible, but it is not a new phenomenon. It is the result of the law that society tends to grow like a plant from below upwards. The Romans, whose patrician families were the most exclusive the world has ever seen, found that these families, far from increasing, had to be added to from time to time by recruits from the plebeians, if they wished to maintain an aristocracy in the State. Of five hundred of the oldest noble families in our own country, only five at the present day can trace their ancestry back, by the male line, to the fifteenth century. There has been no increase here, although our aristocracy have not minded marrying "beneath them" in a way that the Romans would never have dreamed of. A similar tale is told by the nobility of every modern European State. The "advantages" of civilisation do not conduce to rapid breeding of man; the more refined, the more comfortably circumstanced, the better educated classes have not the procreative genius of their less happily circumstanced fellows. In the case of ourselves at the present day, instead of a few aristocratic families enjoying these advantages, we have a large class of independent and professional men whose refinement and education is no whit inferior to that of the "governing caste." Therefore, as this class grows in the community, and it is daily growing, the curtailed birth-rate to which it gives rise affects a larger and larger number of persons, and the gross effect becomes more and more noticeable. It is interesting to speculate on the correlation of these two factors, increased

(a) Supplement to "Thirty-Fifth Annual Report of the Registrar-General," 1876. P. 9.

(b) "Vital Statistics." London, 1899. A. Newsholme, M.D. P. 75.

(c) "Population Question." Dr. Drysdale. *Op. cit.*

(a) "Rate of Mortality and other Statistics of Families." Chas. Ansell. London. 1874. P. 27.

culture and diminished procreative fertility, but in a society where these obtain one finds the subordination of the carnal part of man to his intellectual part to lead to rebellion in the normal physiological functions—pregnancy becomes dystocia, menstruation—dysmenorrhœa, fertility—sterility. It is the principle of having the cake and eating it too, and whether the limitation of the offspring of the upper classes come from low sexual reproductive power, or from the direct intervention of his intellectual processes through celibacy, marital continence, or artificial prevention—or all these combined, as we find at present—these are only the expression of a great social law against which it is no use rebelling. The prosperity of trade has brought more and cheaper luxuries to the homes of the nation, so that the standard of material comfort has risen vastly; this increase of trade has required keener intellectual competition, and the brain has been taxed as against the body. Education has become a necessity of national existence, and education teaches people to think and look ahead. The great present stress in the grapple for bread is an intra-cranial stress acting in a well-fed body; but the stress is none the less keenly felt because it is primarily cerebral, but rather more so. The poor, the less intellectually developed, the serf, can always be trusted to breed; the sexual act constitutes one of their few relaxations—and pleasures. They follow their natural instincts. It is your brain-trained man who, like a wild animal in captivity, refuses to breed. At the risk of repetition it may be asked again whether this fall in the birth-rate may not be the expression of a natural law setting a limit to the too-great multiplication of a hungry, industrial, education-requiring community. It seems, indeed, to be the natural instinct of self-preservation asserting itself at the expense of the reproductive instinct, which two instincts Littré has shown to be the eventual basis of all impulses in ourselves. Dr. Taylor, rather inconsistently, regards these signs as a "handwriting on the wall," and at the same time denies that they are signs of decay. We are inclined to concur in the latter belief. We think they are due not to gangrene but to temporary congestion, and that appropriate treatment may be successful in warding off a fatal termination. He instances Japan as an old nation possessed of new life and activity—a second youth. I hesitate to think that he can attribute this in any way to the sexual morality of that country, which is notoriously deplorable, and her success as a *débutante* in "Welt-politik" must merely be in spite of, and not because of, her inter-sexual arrangements. But what is the result of the over-population of Japan, now that its eyes are opened by education, and that she has found her own strength? A "land-hunger," which Dr. Taylor extols, which shows itself by two bloody contests in a space of ten years, and which may end by inflaming the whole world! We hope for a more prosaic, if less eventful, solution to our own difficulties.

In the case of France there can be little doubt that the decrease in population is due to the adoption of preventive practices by all ranks of society. In other words, the views of the educated class with regard to the undesirability of multiple child-bearing have permeated to the labourers. That process, if continued, must mean fewer persons available for fighting and for the hard work of the State generally. The only remedy, so far as one can suggest, is that the State make the conditions of living easier by a readjustment of burdens, and the cheapening of the necessities of life, while life is at the same time made longer, sounder and more valuable by the development of medical science and administrative hygiene. A similar line of reasoning applies to the falling birth-rate of Australia.

And now to the solution. Dr. Taylor would have the State encourage the fathers of large, well-brought-up families by various aids, financial and educational. Unfortunately, we fear that the State would not be likely to take into consideration the quality of the bringing up of a family; the most that could be hoped for would be that the size of the family should be the qualification for assistance, and this, again, would really

be needed only in the middle classes. The poor have no direct taxation that could be remitted, and their education is already provided for. There is a good deal to be said for this plan, but it would be only an inducement after all, and might not meet with great favour in practice. Next, Dr. Taylor has a somewhat cryptic proposal for the State jealously to guard the earliest possible date at which productive work could be begun by those entering professions. We may say at once that such a matter is in the hands of the professions and the public, and at a day when the cry is all for a higher standard of preliminary education for the professions, it is not feasible. Then Dr. Taylor would make pregnancy less distressing by medical advice, diet, and management. Well, we all do our best as it is, and pregnancy is never likely to be other than a rather trying and painful business for the well-brought-up mother. Finally, Dr. Taylor makes a strong appeal to the forces of religion and morality to aid in putting down artificial prevention, though he is of opinion that occasional abstinence in married life is "allowable."

But is not this treatment merely symptomatic, and would not its effect, if successful, be rather to alleviate than cure the body corporate? And, again, might it not be possibly harmful by increasing the present undue competition of the upper middle classes? And yet again, would it, could it, be eventually successful in the face of natural laws? Unless some new distribution of wealth be unexpectedly brought about, or unless some new fiscal system give an impetus to trade like that given by Free Trade in the middle of last century, or unless some new sources of material wealth be tapped, mere increase in numbers is not wanted in this country for its own purposes. And this being the melancholy fact, the natural industrial conditions of demand and supply will combine to check over-production by some means or other.

In the long run the woman's innate desire to bear children must outweigh the difficulties and dangers incidental to pregnancy and parturition. At present, the prospect of not being able to bring up children weighs heavily on both parents or potential parents of the upper and upper middle classes. It is by means of this fear that the natural law of limitation of upper sections of a population is acting. Its expressions are found in late marriages, celibacy, marital abstinence, and artificial prevention. Now it is apparent that these methods are each and all the result of deliberate choice, that is to say, they are the results of the exercise of judgment and prudence, which, again, are the objects of all education and intellectual development to form. Judgment may decide rightly or wrongly, but it is in itself the highest product of mental training. Therefore, if we find judgment being exercised somewhat widely to limit the population, it must be because many of those in the best position to judge have decided that future increase is baneful. Now, if we admit that celibacy is preferable to incontinence, that late marriage is better than rash marriage, and that abstinence in married life is allowable, we are led to the conclusion that artificial prevention is the last resource available to that class, and it is a large one, of educated persons who desire the domestic advantages of marriage at an early period in their lives, and are not blessed with the power of restraint. That it is a commendable resource we do not argue, but that it is one to be faced fairly and squarely as certain to occur in the present state of society, and one that can be abrogated only by altering the conditions that lie at its root. It is no desire to "make the worse appear the better reason" that forces one into this position. It is no more a condonation of artificial prevention to point out its inevitability than it would be a condonation of prostitution to point out that it always has existed in civilised countries, and must do so if those conditions that produce it remain operative.

The recommendation of Thomas à Kempis, *frequentur tibi violentiam fac*, will indicate an alternative course for such as have not the gift of continence, but human

nature being what it is, there can be no doubt that while the incentive to prevention as to prostitution exists, there will be response to the invitation in certain quarters. We have already indicated our views on the exaggerated importance that we consider has been attached to prevention, as opposed to late marriage, as a factor in the decline of the birth-rate. But if prevention is a constitutional disease as we consider, nothing short of radical treatment will cure it, and in grave illness tinkering remedies are to be avoided. But, beyond the organisation of extensive schemes of colonisation, there remains another prime duty in this matter for the State to perform—that is, the prevention of marriage among criminals, lunatics, and diseased persons. The power of veto is asserted by the State in the regulation of marriage with regard to consanguinity; why should it not be equally enforced in the case of the other more serious conditions? Heaven knows we have enough of all of them at present, and that chronic inebriates, hardened criminals, lunatics, and tuberculous patients should be discharged from institutions with free licence to perpetuate their stigmata to generations yet unborn is a disgrace to a nation that calls itself civilised! Dr. Rentoul has proposed that by a simple surgical operation degenerates should be placed in such a position that the possibility of their propagating their kind should be for ever obviated. It remains to be seen whether such a suggestion will find support from society in general, but a check on the productivity of these classes would be an unmixed gain to any country in the world. While giving Dr. Taylor every credit that his courage deserves, we think that the crusade he advocates would be little effective unless the pressure that leads to the occurrence of these unfortunate conditions can be relieved by some such method as we have advocated.

On the whole, then, I find Dr. Taylor has brought forward little to support his assumption either as to the cause or the effects of the diminishing birth-rate. In a matter of such vast national importance, it is desirable that an exact scientific conclusion, that is to say, the truth, should be arrived at as nearly as may be. Possibly the end might be best approached by way of a Royal Commission of Inquiry, with a full examination of expert medical, social, and statistical evidence. In any case, I think the candid reader will agree with me that the causes of our diminishing birth-rate do not all lie on the surface.

The heads of my own conclusions may be thus briefly summarised:—

1. There has been a fall in the total birth-rate of the United Kingdom during the past half century, while there has been little change in the marriage-rate in the same period.
2. That the fall affects both legitimate and illegitimate births, and is therefore active outside the married state.
3. That the fall, roughly speaking, of the last thirty years was preceded by a proportionate rise during the thirty years before that again. Thus the average total birth-rate of 1840 roughly corresponds with that of 1900.
4. That in order rightly to appreciate the fall of the latter thirty years of the period mentioned, it is necessary to inquire into the causes of the rise in the first thirty years.
5. That the rise may have been due to the wave of national prosperity that passed over the country during the latter half of the nineteenth century, subsequent to—or because of—the introduction of Free Trade.
6. That the diminishing birth-rate may similarly be a delicate index of decreasing national prosperity.
7. That the fall may possibly be due to the fact that under present social conditions the maximum limit of supportable population may have been reached.
8. That the falling birth-rate may be partly explained by the increasing tendency to postpone marriage to a later age.
9. That a portion of the fall—not the main part—may be ascribed to artificial prevention of conception

practised chiefly among the better-to-do classes of the community.

10. That the general tendency among wealthy and patrician classes has always been towards lessened fertility and sterility (*i.e.*, apart from special preventive methods).

11. That increased celibacy must be taken into consideration, as well as the facilities and the relative frequency of divorce.

12. The constant drain of healthy soldiers and sailors lost in active service in various parts of the world must also be taken into consideration. (This point has not been raised in the foregoing article.)

13. That there is no trustworthy evidence to show that the practices of prevention lead to grave physical and moral evils in the parents, and in the non-prevented issue of such marriages.

14. That intellectual limitation of marriage fertility may be an evolutionary manifestation of the highest intellectual development, anticipating thereby the destruction wrought by natural laws upon superfluous individuals in the community.

15. That it is necessary to consider the quality as well as the quantity of the children brought into the world, as well as the chances of their survival to a ripe age.

16. That it is the immediate duty of the State to take steps to check the reproduction of criminals, lunatics, and of grossly diseased persons suffering from heritable maladies.

17. That an enormous proportion of the avoidable disease, insanity, and crime that constitute so great a blot upon our modern civilisation may be traced to the unrestricted multiplication of the children of the poor.

18. That the limit of population in the United Kingdom supportable under present social conditions may have been neared or actually reached.

19. That the soundest remedy may possibly or probably be found in laws that lead to greater equality in the distribution of wealth and of opportunity to the individual citizen.

## The Wightman Lecture

ON

## HEREDITARY BIAS

AND

EARLY ENVIRONMENT IN THEIR RELATION TO THE DISEASES AND DEFECTS OF CHILDREN. (a)

By R. CLEMENT LUCAS, B.S., F.R.C.S.,

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AFTER alluding in sympathetic terms to the circumstances which led to the foundation of the Wightman Lecture by Charles Wightman, Esq., Mr. Lucas proceeded as follows:—The truth of the general axiom that the child must resemble his parents will be universally admitted. The variations in the appearance of the offspring are frequently to be accounted for by the relative vigour of one or other parent. If all the strength be centred in one parent certain peculiarities are apt to arise. Thus, it has been observed in the case of the peerage that marriage with an only daughter is a common cause of the extinction of titles. With regard to longevity, all evidences point to the fact that length of life was being gradually extended by reason of a more widespread knowledge and observation of the laws of hygiene.

When we come to consider what diseases are actually hereditary, we are met with a difficulty at the outset. There are several diseases which were once thought to be of an hereditary nature which we now know are not so. As late as 1863, Dr. Sedgwick stated that pityriasis versicolor attacked all the males of a certain family. Those who believed in the influence of "diathesis" received a rude shock when Koch

(a) Abstract of Lecture delivered before the Society for the Study of Disease in Children, July 16th, 1904.

discovered the tubercle bacillus. The eyes of such distinguished observers of clinical facts as Sir Thomas Watson may even be closed from a too strict adherence to the diathetic theory. When I became attached to the Evelina Hospital for Children, I inquired into the family history of every case of tuberculosis in infants under the age of two, with the result that one or other parent nearly always suffered from phthisis. Are we, therefore, to throw over tuberculosis altogether as a diathetic disease? The so-called "types" of consumptives may be rather considered as an hereditary effect than a cause of the disease. If Cohnheim's theory be true, namely, that the bacilli have the power of penetrating into the germ or sperm-cell, then the outlook of the offspring of tuberculous parents is hopeless from the earliest period of existence.

Up to the time of the discovery of the specific bacillus by Hansen, in 1871, the hereditary nature of leprosy was firmly believed in, and even now, in certain parts of the world, segregation is still practised. But the Indian Commission failed to discover evidences of such heredity in more than 5 or 6 per cent. of the cases. The manner in which the disease is spread only remains to be further elucidated. Together with malaria the above affections must now be classed under the specific diseases.

Passing on to syphilis, which we know descends from one generation to another, we find that it very seldom goes on to the third generation. Mr. Hutchinson says that in eight cases of congenital syphilis he only met with one doubtful instance of transmission to the third generation, and I have notes of only one case. The term "transmitted" is better than "congenital," as better expressing our knowledge of its hereditary character. If both parents are affected with the disease the results are doubly disastrous for the offspring. Here we may note the fact that the later children of syphilitic parents are generally the more robust, in contra-distinction to those of strumous parentage.

There is one disease which is common in large cities, and which is responsible for much of the physical degeneration of the present day, and that is rickets. It is a purely dietetic disease, and it may be induced in any child simply by bad feeding. Its hereditary effects are well seen in puppies.

Now that a special diplococcus has been found in acute rheumatism, this disease also can no longer be considered as purely hereditary. Its antithetic counterpart, gout, can be produced in successive generations, for the children of gouty parents are generally brought up under the same conditions of affluence as themselves. It is possible, nay, even probable, that this malady will be found to be of an infective nature.

Congenital defects due to diseases of the nervous system are fairly common. Dr. Shuttleworth has found that in 20 per cent. of all cases of idiocy a history of mental disease in one or other parent may be obtained. The researches of Galton and Karl Pearson show that certain nervous diseases are not only hereditary but are transmitted in definite proportions to the sons and daughters of the parents so affected. Psychological tendencies are transmitted as well as physical qualities.

Hæmophilia is a disease which presents peculiar characteristics, inasmuch as it selects the males and yet is transmitted by the females. Other abnormal conditions appear to follow the same law, such as colour-blindness and polydipsia. Several ocular defects are distinctly hereditary, such as coloboma and nyctalopia.

It is when we come to external defects, however, that the influence of heredity is most clearly marked. As far as the skin is concerned, ichthyosis is transmitted through several members of the same family, and this for many generations. Psoriasis, in like manner, often runs in families. Such congenital abnormalities as supernumerary digits have been traced through five generations. With regard to hare-lip, I have previously recorded the fact that absence of the lateral incisor tooth in the mother is frequently the precursor of this deformity in the offspring, and I desire to add further

the observation that a feebly developed incisor tooth may, similarly, foreshadow the occurrence of hare-lip in the child. Many instances of the transmission of multiple deformities through successive generations have been recorded in the transactions of this Society, some of which have been conditions of great rarity.

The influence of intra-uterine amputation of limbs and other parts of the body, due to constriction by the umbilical cord, has probably been considerably overrated. There are many arguments which militate greatly against the acceptance of this view, and I would rather suggest that such deformities are due to errors far back in the process of development, perhaps of the nature of incompatibility between the germ and the sperm-cell. Once such a deformity has been well established, it is very difficult to eradicate. The "tyranny of ancestry" has first to be overcome, and this is not an easy process.

The influence of the parents upon the physical deterioration of the present day is even more important than the effects of bad food and surroundings upon the children themselves. Both the health of the parents and the nutrition of their offspring are matters in which the better observance of the laws of health cannot fail to react favourably upon the physical condition of the nation.

### SOME OF THE NEWER METHODS OF OPENING AND CLOSING THE ABDOMEN. (a)

By E. HASTINGS TWEEDY, F.R.C.P.I.,  
Master of the Rotunda Hospital, Dublin.

THERE is no more remarkable fact in the surgery of the present day than the want of unanimity existing as to the best method of opening and closing the abdomen in abdominal operations for pelvic diseases. The propriety of a vertical incision has only recently been called in question. It is still the operation of election among British surgeons, but on the Continent the transverse incision has largely superseded it. This plan, since my appointment to the Rotunda Hospital in November last, I have adopted in nineteen cases, and it is to the result of my observations in these that I now desire to draw attention.

Let me first say that the transverse incision is performed in two ways, different, but not antagonistic, and which of the two the operator adopts depends entirely upon the object he has in view. If his purpose be to obtain the most extensive view ever yet attempted of the pelvic regions, he should proceed as Mackenrodt does in his very radical operation for uterine cancer. The skin, fascia, recti muscles and peritoneum are divided by a long, slightly curved incision, close to and above the pubes; portions of the oblique muscles at either side will probably also be severed, and by this an extraordinarily clear view and extended field will be obtained in which to operate. The incision is a formidable one; necessitating as it does the severance of the muscular supports of the abdomen, the proper union of which can never be hoped for, a weak scar is more than likely to result, and save for the removal of cancer, I know of no justification for such an incision. If, on the other hand, the object is not primarily that of obtaining an extensive view, the second method will be found applicable, and, I believe, preferable in many cases in which a vertical incision has heretofore been made. In it a transverse and slightly curved opening is made at

(a) Read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, Friday, April 15th, 1904.



the margin of the pubic hair, through skin, adipose tissue, and sheaths of the recti. These structures are raised as a thick flap above and below the incision, from the muscles lying beneath them. The division between the recti can now clearly be made out; the latter are separated and the abdomen opened in the usual manner. The advantages of such an incision are manifest. In the first place it runs in the direction of the elastic fibres of the skin, as a rule the parts fall naturally into position on the completion of the operation, and the fear of hernia is reduced to a minimum, the severed aponeurosis is, throughout the greater part of its course, protected by the muscles, and it is only the transverse slit extending between these that could by any possibility permit of the escape of the abdominal contents. The application of a few interrupted sutures, superficially placed in the muscles, sufficient to keep them in apposition until adhesions form between them and their overlying fascia, will effectually prevent the occurrence of hernia. The scar left after such a wound has no tendency to spread. It runs in the direction of the natural wrinkles of the abdomen, and has the added advantage of being covered by the pubic hair.

I have on several occasions curved the incision to a considerable degree, in order to obtain more room. This I now look upon as a procedure to be avoided if possible, as it adds to the unsightliness of the scar. This method of operating should be confined to the less severe abdominal sections. In suitable cases, however, it will, I am sure, steadily gain in favour. On one occasion the fascia did not come easily together, and excessive strain on it had to be prevented by keeping the patient's legs flexed for a few days. One case alone showed slight indications of a stitch abscess at the extreme end of the incision; the operation was undertaken for the cure of an old ventral hernia. It was impossible to sterilise the skin efficiently. The woman suffered from a severe bronchial cough of a chronic character, and as a further complication a pneumonic area of dulness developed after the operation. Finally, I may add that the incision does not lend itself well to the employment of an abdominal drainage-tube.

Hernial formation is unfortunately a very common sequela of abdominal operations. In no less than six instances I have opened the abdomen within the past four months for the relief of this complication. Of these, two were operations not performed in this country, and one of them was so remarkable that it is worthy of being recorded.

The woman entered the hospital some four weeks ago, suffering from the effects of a former abdominal section performed eight years previously. On the evening of her arrival in hospital, during a fit of coughing her abdomen ruptured, and masses of intestines extruded on to the skin, the pubic hair, and sheets. A full hour elapsed before an operation for her relief could be effected, but notwithstanding, I am happy to say her recovery has been uneventful.

The prevention of hernia, is, I think, entirely dependent on a proper *technique*: being followed in the closing of the abdominal wound, in the accomplishment of which the main objects should be strict asepsis, careful apposition of the more important abdominal layers, and lastly the prevention of subcutaneous hæmorrhage. The attain-

ment of these ends will always remain doubtful in the practice of those surgeons who employ the through-and-through suture.

It seems to me a safe precaution to close off the peritoneum (in the first instance; this can be very readily accomplished by means of a continuous suture of fine silk. This No. 2 silk with us antiseptically prepared by being boiled on two occasions separated by an interval of twenty-four hours in 1 in 1,000 corrosive sublimate solution. The object sought by such preparation is to render the silk actively inhibitory to the growth of germs with which of necessity it must come in contact until such time as the phagocytic action of the tissues can exert their full power. Whether the posterior sheaths and recti muscles should be sutured is still a debatable point. For my part I believe such a procedure is not only unnecessary but positively harmful. The union between muscular structures is proverbially weak, and sutures piercing at right angles to their fibres must impair their vitality by strangulating portions of their vascular and nervous supply.

It is no doubt essential to keep the muscles in close apposition, and this can with certainty be done by properly suturing their external sheaths. To attain this end I was formerly in the habit of uniting the sheaths by interrupted sutures of silk-worm-gut placed in mattress fashion after the manner advised by Kelly. This proved most satisfactory, and has only now been abandoned by me in favour of the fine continuous suture of silk for the reason that the latter can be applied more rapidly. The method of suturing above described will almost certainly protect against future hernia, and I need hardly say that in bringing it to your notice I make no claim to originality.

The closure of the skin wound I have not as yet dealt with, and it is in connection with this that I desire to call attention to my recently introduced method which, so far as I know, is novel. I pass a subcutaneous silk-worm-gut suture immediately beneath the skin in the usual manner and thread either end through a perforated leaden plate similar to the one I now show. These plates are cut out of ordinary roof lead; in width they measure about two inches, while its length is made to correspond to that of the incision. The lead can be perforated opposite the ingress and egress of the suture by means of a strong surgical needle. Through these the ends of the suture are passed, and having been drawn taut are tied together over the plate. The plate should be sterilised, and both it and the skin be in a perfectly dried state before its application. Aseptic dressings are placed over the plate, and an abdominal binder applied in the usual manner, the parts being left undisturbed for foretun days. On the expiration of that time the dressings can be removed and will be practically unstained. The suture is now cut and the leaden plate lifted off. It does not adhere to the skin, but will be found to act after the manner of a smoothing iron in procuring exact apposition of the opposing edges, and preventing over-riding of surfaces. The plate affords a ready means of preventing the suture slackening, and does not permit the wound to pucker. Moreover, I feel convinced that the lead itself exercises a favourable influence on the healing process, for I cannot otherwise account for the perfection of the scar.



## The Out-Patient Departments.

### TOTTENHAM HOSPITAL.

#### *Dermatological Cases under the Care of*

G. NORMAN MEACHEN, M.D., M.R.C.P.

#### CASE I.—*Lichenoid Transformation of Scratch Marks.*

—The patient, a married woman, æt. 31, had suffered from an irritable eruption for about six months. Her general health had not been affected, and she had had no previous illnesses. On examination, there was discovered a profuse eruption of lichen planus, the lesions being typically flat-topped, shiny, and more plentiful upon the lower extremities, where their colour was somewhat dusky. No lesions were observed upon the buccal mucous membrane. There were several scratch-marks visible, as the rash was very pruriginous, and upon some of these it could be seen that the linear streak made by the finger-nails was thickly set with small papules showing all the characters of lichen planus. One recent scratch upon the right hand, which the patient stated was inflicted accidentally, also showed the papules in place of the usual superficial blood-crust which forms under normal circumstances as the result of a deep scratch.

Dr. Meachen remarked that the so-called lichenoid transformation of scratch-marks, occasionally met with in this disease, was a most interesting feature. As far as the pathology of the affection went, the condition was, in itself, an evidence that the morbid process was prone to attack those areas of the skin whose resistance was lowered or whose vitality was impaired. He instanced the case described by Dr. West, in which the lichen papules appeared in a scratch-mark inflicted by a kitten before any other part of the eruption appeared elsewhere. The only remedy which really did seem to possess a specific influence upon the course of lichen planus was arsenic, and this patient was therefore put upon three minims of Fowler's solution, thrice daily, to commence with. A weak tar lotion was ordered for local application.

CASE II.—*Prurigo Mitis.*—A little girl, nearly three years old, was brought to the hospital with a very irritable eruption which the mother stated had been present for about eighteen months. She had attended other hospitals. The child was said to be in good health, although its sleep was much disturbed at night by the irritation.

On inspection, the skin over the lower part of the trunk, thighs, and legs, and to a lesser extent over the chest and upper extremities, was covered by a profusion of small conical papules, many of which were surmounted by a blood-crust, indicating the irritable character of the eruption. The extensor surfaces were more affected than the flexor. On passing the hand lightly over the areas the firm nature of the papules could be felt. There were no urticarial wheals nor were there any eczematous patches anywhere. There did not appear to have been any great error in the dieting of the child, for the mother had endeavoured to carry out previous instructions. The bowels were habitually irregular in their action. The glands in the groins were not enlarged, and no other member of the family had ever suffered or was suffering from a similar complaint.

The diagnosis of this case rested upon the papular nature of the eruption, the absence of wheals or exudation, and its chronicity. Itching was always a well-marked symptom of the disease, and the scratching which it evoked was responsible for the secondary lesions which were plentifully seen in the present case. The affection usually commenced at or about the end of the first year of life, and sometimes persisted for several years. Geographical conditions and racial characteristics seemed to have an important bearing upon the prevalence of the disease, for it was distinctly rare in America and it was said to be relatively more frequent among children of the Jewish community.

The treatment of this affection sometimes taxed the ingenuity of the physician to the utmost. Sedatives

were often required at night, a draught of chloral and bromide being suitable for this purpose. Constitutional and hygienic treatment was necessary in the majority of cases, plenty of fresh air and good plain nourishment being enjoined. Cod-liver oil and malt internally was indicated in marasmic infants. To relieve the irritation, lotions of carbolic acid, 1 in 80, or of creolin, 1 per cent., were useful. This child was given 5 min. of the tinct. cinchonæ in the mist. mag. sulph. cum rheo, three times a day.

CASE III.—*Eczema of the Face with Catarrhs of Mucous Membranes.*—A little girl, æt. 3, had suffered from right otorrhœa for a fortnight, and was brought by her mother to the skin department with a "breaking-out" upon the face. A few days before this the right eye became inflamed. There was a typical weeping, papular and crusty eczema of the face, chiefly limited to the right side, but extending downwards a short distance upon the neck. The auricle was also involved, and there was an acute conjunctivitis with photophobia upon the same side.

The association of eczema in young children with various catarrhal affections of the mucous membranes was not unfrequently observed. A running at the nose was prone to lead to an eczematous dermatitis of the upper lip and adjacent parts of the cheeks, while a purulent discharge flowing from the external auditory meatus often determined the appearance and the distribution of an eczema in the immediate vicinity of the affected ear. In such instances the skin affection was clearly secondary to the other catarrhal conditions, and when these were cured the skin got well. Sometimes, however, parents will persist in the statement that the eczema appeared first. Believing, as we do, that eczema is a true cutaneous catarrh, whether it be produced by micro-organisms or not, it is not inconceivable that this morbid process should affect several anatomically allied tissues at the same time. Only upon this theory can we account for the appearance of simple or a phlyctenular conjunctivitis coincidentally with an acute facial eczema. Regarding an otorrhœa in the light of an exciting cause of the skin affection, it is useless to expect much improvement in the latter until the aural discharge be cured.

## Transactions of Societies.

### EDINBURGH MEDICO-CHIRURGICAL SOCIETY. MEETING HELD JULY 6TH, 1904.

PROFESSOR CHIENE, C.B., President, in the Chair.

MR. H. J. STILES showed a girl, æt. 7, on whom he had operated for a large abdominal tumour of long standing. It occupied the upper zone of the abdomen, and while its lower margin reached below the umbilicus, it was chiefly epigastric and extended below the left costal margin. At first sight it resembled a pancreatic cyst or a large hydronephrosis, but as it could be freely moved from below the ribs, and from one loin to the other, it was concluded that it was unconnected either with the kidney, loin, or pelvis. Eventually a probable diagnosis of mesenteric cyst was arrived at, and this was confirmed at the operation, when the cyst was found to be firmly adherent to the muscular wall of the intestine. It was formed of fibrous tissue, covered with peritoneum and lined with endothelium, and had probably developed from one of the lymphatics.

DR. EDWIN BRAMWELL showed (1) an interesting case in connection with Edinger's theory of the etiology of tabes. The patient was a watchmaker who had had syphilis ten years ago. He had dimness of vision and loss of accommodation in the right eye, and Argyll-Robertson pupil in the left eye. There were no other signs of tabes. Edinger's view of the etiology of tabes was that, while a specific infection is the predisposing cause, any excessive functional activity precipitates the lesion. In this case the patient habitually used his right eye a great deal. (2) A case of chronic poliomyelitis in a hammerman. The patient had

gradually progressive weakness of the right arm of three years' duration. Six months ago he had stopped work, and since then the condition had undergone arrest. There was marked atrophy of the upper arm, the biceps being very feeble, the upper part of the trapezius atrophied, its lower and middle parts gone. The supinator longus was also much wasted, and both the latissimi dorsi failed to react to electricity. The deltoid and triceps were intact. It was evident that the muscles involved by the atrophy were those used in the patient's occupation.

Dr. ALLAN JAMIESON showed a case of acne rosacea of the hypertrophic type affecting the nose. The condition had been much improved by slicing off thin layers of the superficial textures under adrenalin and cocaine. (2) A case of lupus vulgaris of five years' duration affecting the nose, upper lip, hard palate and gums. Treatment by the X-rays had had little effect, but the use of radium bromide for twenty-two hours in all had produced an almost complete cure.

Mr. F. M. CAIRD showed (1) a patient after removal of a large right-sided renal tumour (nephroma). The patient's hæmoglobin was down to 48 per cent., he had heart disease, bronchitis, and ascites, and was in a very precarious condition before operation. He had enucleated an enormous tumour of a somewhat rare nature, growing as it did from the adrenal and swallowing up the whole kidney. (2) A woman, æt. 54, who had heart disease, ascites, and bronchitis, and symptoms of chronic obstruction, from whom he had removed a carcinoma of the transverse colon. The tumour was the size of the fist, and had been taken away along with a piece of the bowel, the ends being reunited by end-to-end suture. (3) Coxa vara in a boy, æt. 7, who had had difficulty in walking for two years. He had a peculiar swinging gait, the hip-joints were freely movable, but abduction was impossible, and skiagrams showed that the neck of the femur formed almost a right angle with the shaft.

Mr. J. W. DOWDEN showed a man, æt. 60, two years after an extensive series of operations for epithelioma of the floor of the mouth, and (2) a patient two years after removal of epithelioma of the lip.

Dr. R. A. FLEMING showed a patient who, since 1901, had been subject to curious attacks of a sensation of suffocation whenever she laughed or coughed. Nothing could be found to account for the spasm, which in some ways resembled whooping-cough, there being a short, gasping inspiration and a long wheezing expiration with a cough between the two phases. The condition was obviously nervous and great benefit had followed the use of high frequency currents, though other remedies had previously done little good.

Mr. J. M. COTTERILL showed (1) a man, æt. 52, who had had a tumour of the liver for three years. The probable diagnosis was sarcoma, but removal of a piece of the growth for microscopic examination had revealed nothing definite. A month ago the patient had developed a large swelling of the epididymis, which suggested that the condition might be syphilitic. (2) A boy with congenital deformity of the ear, jaw, and face, and spina bifida.

Mr. A. SCOT SKIRVING showed a girl with peculiar arrest of development of the fourth metacarpal bone.

Sir THOMAS R. FRASER gave a communication on  
A CASE OF COMPLETE TRANSPOSITION OF THE VISCERA WITH CEREBRAL TUMOUR AND OTHER PATHOLOGICAL CONDITIONS.

After briefly referring to another case of the same condition, which had been under observation on a previous occasion, a description of this case, that of a man, æt. 24, in which the diagnosis had been made during life and confirmed after death, was given. The patient was already aware of his peculiarity, his attention having been drawn many years ago to the fact that his heart was beating on the wrong side. In consequence of this, he was seen by Dr. Bruce, of Glasgow, who had made the diagnosis and described the case in the *Glasgow Medical Journal* for 1895. He was admitted to the Royal Infirmary on account of pyuria and paroxysmal headache. On physical examination,

a complete transposition of all the viscera—heart, stomach, liver, spleen, and large intestine—was made out. He also had a supernumerary thumb on the right hand. The urine contained pus, but no tube-casts, and the diagnosis of pyelitis was made. Examination of the nervous system revealed the fact that he was right-handed, and that he had congenital anosmia. The headaches were of such a nature as to suggest intra-cranial pressure, but the diagnosis was not at first clear, and was only confirmed several months later when he returned to the Infirmary on account of their increasing severity, associated with blindness. He died somewhat suddenly without any further definite cerebral symptoms. On post-mortem examination a cyst, about the size of a marble, was found in the centre of the brain pressing on the left foramen of Monro, and the condition of the viscera referred to above as ascertained by clinical examination was confirmed. The rarity of cyst in this position was referred to, and the literature of transposition of the viscera shortly discussed. While many cases were upon record, in only a few had the diagnosis been made ante-mortem. A minute anatomical investigation of the viscera had been carried out under the supervision of Professor Cunningham, and beyond the fact that there was a complete transposition of the organs extending to the minutest arteries and nerves, kidneys, pancreas—in short, to all the structures of the body—no anatomical peculiarities had been detected.

The paper was discussed by Dr. EDWIN BRAMWELL, who mentioned a case of cyst of the brain in exactly the same locality, which had come under his notice some years before.

Dr. W. G. SYM read a paper on

METASTATIC GONORRHOEAL CONJUNCTIVITIS,

Ordinary conjunctivitis occurring in the subjects of gonorrhœa was a very acute inflammatory process indeed; it began unilaterally, and the second eye was infected from the first. There was great chemosis, profuse discharge, commonly ulceration of the cornea, and numerous gonococci were present in the pus from the eye. The symptoms of the metastatic form were quite dissimilar; it was more allied to the joint affections and iritis of gonorrhœa, was subacute with slight watery or mucoid discharge, few gonococci; while ulceration of the cornea was rare. He had seen two cases only, briefly as follows:—(1) A man had had gonorrhœa three months previously and the discharge had stopped three weeks before the eye symptoms set in; along with the conjunctivitis several joints became painful, these symptoms improved and then there was a relapse. There was moderate injection of the conjunctiva with secretion of watery muco-pus, a small peripheral ulcer of the cornea and some hyperæmia of the iris which might occur along with any corneal ulcer. The left ankle and wrist were inflamed. No bacteriological examination was made. (2) A male who had suffered from gonorrhœa for three weeks, but never very badly, as he had been carefully treated from the first. The possibility of direct infection was excluded. Conjunctivitis had been present for three days, but was not very severe—very much resembling a moderate case of ordinary catarrhal conjunctivitis. The ocular conjunctiva was injected, and the lids swollen. The patient complained of no rheumatism, but on being questioned admitted that he had had pain in the shoulder for about twenty-four hours, to which, however, he had paid little heed. Subsequently, other joints became involved. A few gonococci were found in the conjunctival secretion, though with some difficulty. Recovery under the use of sublimate lotion and protargol was complete, but the joints were somewhat obstinate. Direct infection here was excluded by the care which the patient had taken, the bilateral onset, and the presence of joint effusion. These two cases were the only ones Dr. Sym had met with, and the condition was not even referred to in most of the text-books. It had, however, been discussed at the Ophthalmological Congress at Utrecht, and at the British Medical Association Cheltenham meeting. The origin of the condition was uncertain; probably it

was due to the bacterial toxins rather than to the bacteria themselves, as dead cultures of gonococci produced a mild conjunctivitis in animals. Probably the disease was not very rare, and it was well that ophthalmologists and surgeons who saw many cases of venereal disease should bear in mind its existence.

Dr. LOGAN TURNER read a paper on

OBSERVATIONS ON THE OPERATIVE TREATMENT OF CHRONIC SUPPURATION IN THE FRONTAL SINUS.

The author first pointed out that a great deal had been written upon this subject, and that probably the literature would be still further increased owing to the fact that we had not yet arrived at a perfectly satisfactory method of dealing with these cases surgically. Relapses not infrequently occurred, a considerable number of post-operative fatalities had been recorded, and the question of disfigurement was a prominent one in connection with the removal of bone in the region of the forehead.

Many operations had been devised, but whatever might be the *technique* of the operation performed, there were two principles underlying the various methods of procedure. First, opening the sinus through its anterior wall, curetting the cavity and draining into the nose, an operation associated with the names of Ogston-Luc; secondly, obliteration of the sinus by the removal of the anterior bony wall of the cavity only, or of its anterior and inferior walls. Evidence was then brought forward to show that opening and draining the sinus was, in a large number of cases, an unsatisfactory procedure. Anatomical reasons were to be found in the varying extension of the sinus upon the forehead and into the roof of the orbit, and also in the recesses and partial subdivisions of the sinus which might be completely overlooked through a moderate-sized opening made in the anterior wall of the cavity. Again, the inability to deal thoroughly with the ethmoidal cells so frequently affected along with the frontal sinus led to re-infection of the latter cavity. Statistical tables were shown illustrating the failures that had occurred in the hands of different surgeons and a table was given showing how much more frequently death had followed the operation of opening and draining the sinus than when the obliteration method had been carried out. The obliteration operation was then considered, and the better results thus obtained were demonstrated. The question of comparative disfigurement in the two operations was discussed and illustrated by results of operative interference. Finally, the Killian operation was described and its merits discussed, and the hope was expressed that possibly this procedure might come to be recognised as a distinct advance in dealing with these troublesome cases. The paper was illustrated by a large number of lantern slides and stereoscopic photographs.

REPORT OF THE OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM ON SIGHT-TESTING BY SPECTACLE-MAKERS.

The Ophthalmological Society of the United Kingdom, having had its attention called to the fact that the Worshipful Company of Spectacle-Makers proposes to include the subject of sight-testing in the examination for its diploma, and to give certificates of efficiency therein, wishes to express its opinion that, while approving of any measures which tend to increase the efficiency of opticians in their technical work, it considers that it would be misleading and dangerous to the public to countenance any proposal to certify as competent to advise and prescribe for defects of vision anyone who has not had an efficient medical and surgical training. A diploma such as the Worshipful Company of Spectacle-Makers proposes to grant may lead the public to believe that its possessor is competent to diagnose and treat diseases of the eye, and thus grave consequences might follow. Errors of refraction often occur in association with diseases of the eye. The mere correction of the former by means of spectacles would ignore a condition which might destroy sight, or even leave the life of the patient in danger.

Moreover, many errors of refraction can only be accurately measured after the local use of a drug, which should only be employed or prescribed by a medical man, since its indiscriminate use is calculated to excite one of the gravest diseases to which the eye is liable. Finally, on general grounds it is undesirable and dangerous to encourage the public in the belief that affections of any organ of the body can be safely treated by anyone unacquainted with its anatomy and physiology, and with the various morbid conditions to which it is liable.

(Signed) JOHN TWEEDY,

July 8th, 1904.

President.

## British Health Resorts.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

### II.—ILFRACOMBE.

ILFRACOMBE is the largest and most popular health station and holiday resort on the north coast of Devon. It lies in a natural basin and is surrounded by high treeless moorlands, except on the north side, which lies open to the Bristol Channel. On the east, protection is afforded by Hillsborough Hill, some 450 feet in height, while to the west stretches a succession of undulating hills. The southern limit of the urban sanitary district of Ilfracombe is constituted by a range of hills 600 to 800 feet in height. The marine slope ends more or less abruptly in rugged weather-worn cliffs. The soil is thin and the rocks are wholly shale over sandstone and grit. There are a few pockets of mountain limestone and a small amount of poor clay.

The climate is particularly mild and equable, due, in great measure, it is claimed, to the influence of the Gulf Stream. The Royal Meteorological Society have obtained a continuous series of records since 1875, and according to the last report of the medical officer of health, the average winter temperature is 44.9°; for the months of February, March, and April, 44.6°; and for summer, 57°. The daily range of temperature is 8.5°. Dr. E. J. Slade King's report also states the birth-rate as 17.9 per 1,000, and the death-rate 14.1 per 1,000; but excluding the deaths of visitors the true death-rate appears as 11.3 per 1,000. The infant mortality is equivalent to 134.6 per 1,000 born. The district shows no marked prevalence to special forms of disease. Phthisis is comparatively infrequent. A system of voluntary notification of consumption is in use. The isolation hospital is modern and well-equipped, but scarcely sufficiently distant from the newer part of the town. The sewerage and drainage have recently been much improved, and the new water supply which is to be drawn from Challacombe, on Exmoor, appears from our analysis to be of great purity and well suited for drinking purposes. The inhabitants are chiefly engaged in occupations dealing with the provision for visitors. There are large numbers of apartments and many good boarding-houses, but first-class hotel accommodation is limited. The marine walks and hill paths, together with the public pavilion, are designed to meet the wants of the holiday-maker rather than of the invalid. The beaches afford no sandy stretches and are generally unsuited to the requirements of children, but afford facilities for convenient bathing stations. There is also a well-equipped public swimming bath.

Ilfracombe is a particularly good centre during the summer season for coaching and steamer excursions. It is thus readily seen that the attractions of the place are more likely to appeal to the young and vigorous than to the aged and enfeebled.

Ilfracombe, however, can offer not a few conveniences for the invalid. Its equable and bracing climate, its easily accessible walks with numerous shelters and resting-places amidst picturesque surroundings, make for the reinvigoration of convalescents and the recreation of the overworked. Certain cases of neurasthenia could be sent here with advantage. It claims to take rank as a winter resort, but from all we

can gather the prevalence of wind would militate against its usefulness for many cases at that season of the year. Access to Ilfracombe may be obtained by a number of different ways. A direct service from London (Waterloo) is provided by the London and South-Western Railway, and during the summer months a through carriage is run from Paddington by the Great Western Railway. Visitors from the North and Midlands travel to Bristol, from whence they continue by rail on the G.W. system, or during the summer months by steamer. Visitors from Wales may often conveniently cross the Bristol Channel in well-equipped steamers starting from Swansea. In the summer season the comparatively vigorous traveller may obtain a pleasant mode of access by travelling to Minehead on the G.W.R., and thence proceeding by coach through the pleasant resorts of Porlock and Lynton to Ilfracombe.

We strongly recommend this bright, bracing and attractive town, which is rich in facilities for the building up of the natural powers of resistance, to the attention of physicians and all interested in what we may term the "prophylactic influence" of a wisely selected holiday resort.

For many useful particulars see:—

(a) Medical Officer's Report of the Urban Sanitary District of Ilfracombe.

(b) An Official Guide to Ilfracombe is also published by The Health Resorts Association, 2 Gray's Inn Road, High Holborn, London.

(c) A useful handbook to Ilfracombe and district is issued by Messrs. Ward, Lock and Co., London.

### Continental Health Resorts.

#### THE BRENNER-BAD IN TYROL.

AN AUSTRIAN HEALTH RESORT NEW TO MANY OF OUR READERS.

THIS Alpine Spa, although at an elevation of almost 4,000 ft. above ocean level, is really very accessible. It is located immediately on the main line of railway running from Italy to Germany, six hours from Verona, five hours from Munich, and by express trains only an hour and a half from the central and junction station of Innsbruck.

This route, either southward or northward from Brenner, is one of the most picturesque of the famed Southern Railroad of Austria, noted alike for the novelty and grandeur of the countries it traverses and for the comfort of its carriages.

Of itself, the Brenner ranks deservedly high amongst the most celebrated of Alpine Passes. The mineral springs, baths, and hotels are located at the most beautiful position in this notable Pass, and at the centre of attractive excursions by foot, carriage, or rail. Pleasant hill-sides and woods are around the place, rich pasture-lands, swiftly flowing streams, and exquisite Alpine flora. It has thus many attractions for the artist and botanist.

For those seeking a summer sojourn with a temperature unusually mild and agreeable for so high an altitude, and for those desiring a rest or air cure, the excellent hotels and novel surroundings at Brenner-Bad have many inducements. Completely sheltered by heights from northern and easterly winds, it lies open southwards to the glorious Italian sun, in this respect differing greatly from many mountain health-resorts, which are usually in confined valleys. At Brenner is a constantly changing air-current, revived and aromatised by passing through and over fields, forests, and sunny peaks.

Quite apart, therefore, from its medicinal waters, Brenner-Bad has good claims for favourable attention. Its Mineral Springs, too, have enjoyed for several hundred years local celebrity because of their unquestionable efficacy in even chronic cases of gout and rheumatism; in many cases of diseased limbs their use is specific.

In the year 1608, a prominent and patriotic patrician of the ancient city of Sterzing bequeathed to his ancestral town the bath buildings he had erected for

public benefit at Brenner. Hotels and other accommodations were gradually added thereto by the municipality of Sterzing which owned these Thermal Springs. In 1899, the property was transferred to the present company, who have erected up-to-date hotels, and new bath buildings, containing the latest and most approved appliances for hydrotherapeutic and electrotherapeutic treatment; so that to-day the Brenner-Bad offers the combined advantages of an exceptionally fine Alpine "climaterique cure" with a very valuable "mineral-water cure" added, combined with modern comforts, good resident medical attendance, and beautiful Tyrolean surroundings, picturesque and novel in life and characteristics.

Professor Barth's analysis of the solid residuum of 1 lb. (6,780 grains) of Brenner-Bad mineral water:—

Sulphate of potassium .. ..	0,128862
Sulphate of soda .. ..	0,110332
Sodium chloride .. ..	0,078276
Magnesium chloride .. ..	0,045755
Sulphate of lime .. ..	1,217345
Carbonate of lime .. ..	0,348989
Carbonate of magnesia .. ..	0,343128
Carbonic protoxid of iron .. ..	0,026726
Silicated argillaceous earth .. ..	0,005546
Free silica .. ..	0,069085
Phosphoric argillaceous earth .. ..	0,002115

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 17th, 1904.

#### A NEW SIGN OF PLEURITIC EFFUSION.

PROF. GROCCO has published a new symptom of pleuritic effusion, easy to discover and of considerable value.

When a liquid of any kind is present in the pleura, a dull zone of triangular form can be found by percussion on the opposite side. The internal edge corresponds to the vertebral spinous apophyses; the base, from one or two inches in length, corresponds to the point where the normal thoracic sonority ceases, while the external edge follows an oblique ascending line, intersecting the internal side of the triangle at the upper limit of the effusion. This dull surface varies in extent with the quantity of liquid, and diminishes when this liquid tends to absorption. The dullness is more marked near the median line and the base of the triangle; a decrease in the vesicular murmur is also perceived by auscultation.

Badnel and Siciliano experimentally studied Grocco's symptom and its varieties by slowly injecting liquid into the pleural cavity of corpses, and gave the following explanation—the pleural *cul de sac*, distended by the effusion, is displaced and, passing in front of the vertebræ, exceeds more or less the median line; it thus pushes before it the mediastinum into the opposite side of the thorax. At this point dullness will consequently exist, provoked by the presence of liquid contained in the distended pleural *cul de sac* and the displaced thoracic organs. The compression by the displaced heart of the lung, which becomes more dense, also favours the production of the dullness.

The mediastinal organs are much more displaced by effusions on the right side than on the left. The aorta, as everyone knows the most important organ of the mediastinum, is, when in normal position, on the left of the median line. Consequently in effusion into the right pleura, the artery becomes easily displaced towards the left, bringing with it the whole mediastinum; where the left pleura is affected, the aorta can only be pushed a little towards the right, while the other organs sliding over it fell to the right side of the thorax.

The new clinical sign described by Grocco is valuable for diagnosing slight effusion into the pleura. It permits particularly to distinguish spleno-pneumonia from pleurisy, which reveals itself by identical physical symptoms, and cannot be suspected until after several small operations with the exploring needle have remained without result; the absence of the triangle of Grocco will put down to spleno-pneumonia the symptoms attributed at first to the existence of a pleural effusion.

#### ADRENALIN.

A very interesting study of adrenalin by H. J. Noé, appears in the *Archives Gén. de Méd.* for June 28th, 1904, in which a full statement is made as to the history, the process of extraction, the physical and chemical properties, and the constitution of adrenalin, together with a process for the colorimetric estimation of the substance. In January, 1901, Takamine first announced his discovery in the suprarenal capsules of the base, to which he gave the name adrenalin. Later in the same year Von Furth perfected his process for the preparation of suprarenin, and obtained an iron compound in the form of an amorphous violet powder, and after elimination of the iron by acid he produced a substance which he declared was the same as Takamine's adrenalin.

Various considerations lead to the supposition that the name adrenalin does not correspond to products always identical in themselves and well defined chemically. These considerations led M. Canjon in his thesis read before the Paris Faculty of Medicine to state that "all these products differ considerably in their physiological action and in their toxicity. The different methods of extraction give substances very dissimilar, and to such a degree has this come that very experienced practitioners who have had occasion to use adrenalin from different sources either experience remarkable success or complete failure. The active principles of the capsules of different animals, oxen and sheep, for example, all having approximately the same appearance, and having chemical reactions in common, have not the same physiological action." Reviewing this part of the subject M. Noé remarks that it is necessary, to avoid misconceptions, to make use only of products of which one already knows the effects.

The process for the extraction of adrenalin is then considered, and considerable space is devoted to the physical and chemical reactions of the base. Adrenalin is very soluble in acids and forms salts which crystallise with difficulty; the hydrochloride, sulphate, tartrate and benzoate have been prepared, but the first named is preferred on account of its greater solubility in water. With regard to the constitution of adrenalin, M. Noé quotes Jowett, who confirms Aldrich's formula, which also had been adopted by Von Furth and Pauly. The last portion of the paper deals with a colorimetric process for estimating the value of the base, proposed by Battelli; but numerous critics, quoted by M. Noé, are of opinion that the process is very unsatisfactory.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 17th, 1904.

At the Free Society of Surgeons, Hr. Braun spoke on

#### POST-OPERATIVE DISTENSION OF THE STOMACH.

He had seen five cases of acute ectasis of the stomach, two of them after extirpation of the vermiform appendix, two after laparotomy for ruptured tubal pregnancy and one after a gall-stone operation. This was

to be looked upon as primary atony of the stomach made worse by absence of vomiting; what was the cause of the reflex nervous phenomenon had not been yet explained. He had made experiments on the subject which were not yet completed, and had observed that one could blow up the stomach of a chloroformed animal through a gastric fistula without exciting vomiting. Vomiting came on more readily when the animal had not been anaesthetised.

The most important was prophylaxis, the mere washing out of the stomach as soon as the first symptom appeared.

Hr. Birchardt reported a case of enormous distension of the stomach after nephropexy. Death took place in a short time.

Hr. Körte had done gastro-enterostomy in a case of distension of the stomach coming on without a previous operation. The stomach remained distended. Death took place from necrosis of the wall of the stomach and peritonitis. The case was one of atony from over-distension.

At the Medical Society Hr. Orth showed

#### A CYSTICERCUS OF THE PIA MATER.

He had been interested to know whether there was any diminution in the frequency of this disease, and for the purpose of ascertaining he had gone through the registers of the Pathological Institute. From these he had learned that cysticercus of the brain had notably diminished since 1875, and especially during the past five years. He had only found one case during this latter period. He also showed an echinococcus situated in a branch of the portal vein, and thus stuck fast on its way from the intestinal canal to the liver. He had made similar inquiries in regard to echinococcus as he had done for cysticercus, and had ascertained that no material change in the frequency of its occurrence had taken place during the last thirty years.

The *Deutsch. med. Zeits.*, No. 53, relates a

#### CASE OF PURULENT PERICARDITIS TREATED SURGICALLY.

The patient was a man, æt. 28, who had been struck on the chest by a beam. After this he had a rigor, and his breath became short. The latter was so bad that the patient had to maintain the sitting position. A phlegmonous swelling was seen on the right side of the chest, and at a spot between the second and third ribs there was fluctuation. The lungs were healthy. In view of the excessive dyspnoea and lowered blood pressure, for the kidneys were scarcely acting at all, pericarditis *per continuationem* was suspected. The following day an incision was made at the level of the third rib, when it was ascertained that there was a large abscess just below the pectoral muscles and necrosis of the rib. As the swelling bulged forward here a scalpel was introduced at the spot, the scalpel entering the pericardium near the great vessels. The cardiac action was at first irregular, but as the abscess cavity drained the pulse became more regular again. About 1½ litre of pus was evacuated. The heart was floating above the abscess. Drains were inserted, but the cavity was not washed out. On the twelfth day the drains were removed; on the fifteenth the patient was allowed to sit up, and on the twenty-first he was discharged. Three months later the cardiac dimensions were about normal, the pulse being 72 to 76 when at rest, but rising to 100 when the patient moved about.

At the Society of Charité Aerzte, Hr. Ziehen showed a case of

#### APHASIA.

The patient was a woman, æt. 60, who had a hole in her bony skull. She was a drunkard and probably

syphilitic. Disturbances of speech came on suddenly. In going on to speak of some advance in our knowledge of aphasia he said there was a sharp distinction between the sphere of acoustic perception and that of acoustic recollection. The latter could be disturbed in a brain in which power of hearing was retained. Perhaps a word was recognised, whilst for understanding it other parts came into consideration. In such cases it was always of interest whether optic receptivity and recollection were retained. In the case before them the tract to the optic sphere was intact. Total loss of both was very rare. Exhaustion also played a certain part. Transference from Broca's centre to that of Werneck was absent. When it took place, the route need not be direct, a circuitous one over the optic centre was always possible. In reading there came into consideration—the visual sense, the reading centre (Naunyn), the sphere for sound images (Klangbilder) (Wernecke), and the object presentation in the visua sphere. The recording centre had been disputed, but the objection was not justifiable. The reading centre, however, presented only the optic recollection of the image of the letters. There was a difference here between educated and ignorant patients. Such disturbances as were present in the case before them were pathological—anatomically perhaps worse than they were from a clinical psychological point of view.

What the disease was was difficult to say: perhaps there was a tumour, perhaps syphilitic changes.

Hr. Seiffer showed

#### TWO CASES OF PERIPHERAL PARALYSIS.

The first patient had influenza, pneumonia, and phlebitis and wasting of the right upper arm, the latter from paralysis of the musculo-cutaneous nerve, from which all the parts supplied by the nerve were affected; only ten to twelve such cases were known. Trauma was generally the cause, but in two it was caused by infection.

The other case was one of paralysis of the deltoid from paralysis of the axillary nerve. It followed an operation on a cervical rib. There was no atrophy and no reaction of degeneration.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 17th, 1904.

#### PSEUDO-HERMAPHRODISM.

At the Gesellschaft der Aerzte, Swoboda showed a child, *æt.* 1, with genitals that appeared at the first glance to be female, but a closer observation revealed a more complicated state of affairs in the addition of testicles and præputium arising from the vulva major. The urine was discharged from an opening at the lower part of the penis. Further investigation with sound and digit failed to reveal the sex. There was no justification for opening the gland for microscopic purposes, and hence the case was left undetermined whether the patient was male or female, leaving legislators to provide for a third abnormal sex.

Foges said the diagnosis of these cases was a very difficult task when the patient was so young. Happily, the functions of such glands were inactive, which further added to the difficulty, but he considered operative interference unwise at the present time.

#### TEARING OF THE MESENTERY.

Schnitzler exhibited a child, *æt.* 10, on whom he operated for internal rupture after being run over by a vehicle. On opening the abdomen a large rent was found in the mesentery with invagination of eight centimetres of small intestines, of recent

origin, which, he thought, might be caused by the contused wounding of the bowel producing a spasmodic action and final invagination.

Exner differed from Schnitzler in presuming the invagination to be a simple spasm. He considered it a physiological result due to the loss of co-ordination between the circular and longitudinal muscular fibres of the bowel.

#### ACNEFORM TUBERCULIDES OF THE SKIN.

Arising out of a previous discussion on atrophica cutis idiopathia, Ehrmann brought forward several cases bearing on the subject. The first was one having a variety of phenomena, but all pointing to a tuberculous form of the cutis. The neoplastic growths ranged from the size of a hempseed to that of a pea, having a bluish colour with a necrotic centre; along with these were larger erythematous indurations about the size of beans, having a dark red colour with a cheesy centre.

Alongside of these cases he brought a few of atrophica cutis idiopathia for comparison.

Sternberg said he had made a microscopic examination of the patients with the atrophica cutis idiopathia and found a state of hemosiderosis present.

#### UTERINE CARCINOMATOUS OPERATIONS.

Wertheim next treated the Society to a long history of uterine operations, comparing his own experience with other operators, ancient and modern. The best measure of the success in a uterine operation was the period of immunity after operation. The most successful operators removed the uterus, parametrium and all the glands in the region affected, which can only be done by the laparotomy method. He divided the period of recurrence into three for comparison. He had now fourteen cases over four years since operation, or 29 per cent. The corresponding numbers given by other authors are—Chrobak, 7·2 per cent.; Schauta, 5·1 per cent.; Zweifel, 9·5 per cent.; and Pfannenstrel, 6·8 per cent.

Those recurring between three and four years in his own experience was 27·5 per cent. survived; while Chrobak records 7·4 per cent.; Schauta, 6·6 per cent.; Zweifel, 10 per cent.; and Pfannenstrel 7·1 per cent. Surviving after two years were Wertheim, 31 per cent.; Chrobak, 8·5 per cent.; Schauta 8·6 per cent.; and Zweifel, 11·6 per cent. He thought these results were due to the advantage laparotomy had over vaginal extirpation. Discussion on the subject was reserved for a future meeting.

#### HÆMOLYSIS.

At the Congress für innere Medizin, Koeppé gave the results of his experiments on the solution of red blood corpuscles. The methods adopted in this inquiry go under different names, but the resulting phenomena are much the same. Hæmolysis signifies a previous morbid condition which has hitherto baffled the investigation of the experimenter as to the proximate cause, although the immediate cause is a rapid decline and death of the cell. In examining the immediate causes a series of conditions leading to dissolution may be cited and arranged *seriatim*:—(a) water hæmolysis, (b) caloric hæmolysis, (c) alkali hæmolysis, (d) acid hæmolysis, (e) fatty hæmolysis; and finally the sera, toxin and hæmolysin hæmolysis. The true cause of these changes in the blood cell or hæmolysis is the wounding or solution of continuity of the pellucid wall of the red blood corpuscle. This membrane contains a fatty or lipid constituent with an albuminoid coagulating substance. The water or hydro-hæmolysis is more of a mechanical agent than chemical, as it distends the cell by an internal osmotic pressure. Again mechanical injury is caused by cold or freezing, and thawing of the cell wall as well as by electric shocks



In caloric hæmolysis it seems to be due to a melting of the wall or solution of the fatty constituent. In acid hæmolysis the fatty constituent of the wall undergoes a catalysis in the alcohol formed from the acid, finally splitting up the fatty constituent. In the alkali hæmolysis a saponification in the alcohol with a resulting fatty salt is the final transformation. In all the sera hæmolysis the albuminoid constituent of the cell wall is the element attacked.

## The Operating Theatres.

### ST. MARK'S HOSPITAL.

**ABDOMINAL FIXATION OF THE SIGMOID MESO-COLON TO RECTIFY RECTAL PROLAPSUS.**—Mr. SWINFORD EDWARDS operated on a man, æt. about 60, who was suffering with procidentia recti, which had followed a Badenhauer's excision of the rectum for malignant disease eighteen months previously. The patient had been put to great discomfort owing to the rectum prolapsing some three or four inches from the sacral anus on the slightest exertion, so Mr. Edwards proposed to sling up, as it were, the lower part of the large intestine by means of an iliac incision, supplementing this operation, after the lapse of a week or two, by the repairing of the anus as is carried out for the repair of a ruptured perinæum. The ordinary incision was made in the left iliac region as for an inguinal colotomy, though the incision was placed a little nearer to the middle line and somewhat lower down. The muscles and aponeuroses having been divided in the direction of their fibres, the peritoneum was incised and the abdomen entered. The sigmoid flexure was brought out of the wound and pulled taut at its distal end, the slack being passed back into the abdomen. The tautened meso-sigmoid was now sewn by fine silk sutures to the peritoneum, and to the inner surface of the muscular wall, about half an inch from the lower lip of the incision, and the abdominal wound closed in layers. Mr. Edwards said that he should not rely entirely on this operation to cure the procidentia, although, no doubt, it would help in doing so; but he proposed, if all went well, to lessen the size of the sacral anus and thus bring two forces to bear for the relief of the prolapsed gut, the one being on the principle of *vis à fronte* and the other on the principle of *vis à tergo*. He remarked that he had carried out a somewhat similar operation some little time previously in which he had endeavoured to fix the rectum in a case of procidentia recti to the tissues about the coccyx, but as this was not attended with any success he had discarded it in favour of iliac fixation, of which he had had two successful cases.

The patient a fortnight after operation had shown no trace of any prolapse, but then he was still confined to his bed, and Mr. Edwards proposes to do the second part of the operation, namely, tightening up the anus, immediately.

### CANCER HOSPITAL.

**GASTRO-ENTEROSTOMY FIFTEEN MONTHS AFTER PYLOROPLASTY.**—Mr. BOWREMAN JESSETT operated on a woman, æt. 46, who had, in January, 1903, been admitted for symptoms lasting then for some two years—constant vomiting, nothing being retained on the stomach, and the woman was losing flesh rapidly. The weight at the time of the first pyloroplasty in January, 1903, was seven stones. At this operation, on opening

the stomach the pylorus was found tightly strictured; an old ulcer, partly cicatrised, was seen at the posterior edge of the pylorus. Mr. Jessett divided the pylorus longitudinally for about three inches, and then sutured the surfaces together laterally, first of all suturing the mucous membrane with catgut, and then the serous and muscular coats with fine silk. The patient made an excellent recovery, and was discharged about three weeks after the operation. She remained well for some nine months, after which the old symptoms began to return, but in November of the same year she had picked up four stones in weight, then weighing eleven stones. Since then, she had been gradually losing flesh again, and at Christmas vomited up about one and a half pint of dark fluid. In March, 1904, she was again admitted into the hospital, her weight then being nine stones, she having therefore lost two stones in the four months. When re-admitted she was in fairly good health, but complained of a good deal of pain after food, most of which she vomited shortly after taking it. Mr. Jessett then performed gastro-enterostomy. He opened the abdomen along the left line, the incision commencing about an inch and a half below the costal cartilages, and extending downwards about three inches. The stomach was drawn out and a loop of jejunum also hooked up. He then proceeded to fasten the jejunum to the anterior wall of the stomach, close to its greater curvature. He at first applied a continuous fine silk suture, passing through the serous and muscular coats of the stomach and the jejunum, enclosing in a circular form a space some three inches long by two wide, leaving the ends long and ceasing about two inches from the completion of the oval. He next incised the stomach transversely for two inches, and the jejunum longitudinally for the same distance, and, with a continuous suture, stitched together the cut surfaces of the stomach and jejunum, completing the junction and thus ensuring a free opening between the two viscera. He then with the first suture continued the fastening of the serous and muscular coats. Mr. Jessett next introduced a few stitches through the serous and muscular coats of the proximal end of the jejunum, fastening it to the stomach wall to prevent any kinking; finally, he brought together the parietal wound in four layers, *i.e.*, three layers of buried suture and one for the skin. Mr. Jessett said that he thought this case illustrated very well the effects of gastro-enterostomy as against pyloroplasty. He pointed out that it has often been a question how far the pylorus, after being stretched by Loreto's operation or divided and enlarged by pyloroplasty, may become contracted again; the present case, he thought, illustrated that in every instance of pyloric obstruction it would be wiser to at once perform gastro-enterostomy in preference to interfering with the pylorus. Mr. Jessett also drew attention to the method he had adopted in performing the gastro-enterostomy; he used no bobbins or Murphy's buttons, but simply fastened the jejunum to the stomach by two circular continuous sutures, one passing through the serous and muscular coats and the other fastening the cut edges of the stomach to those of the jejunum. He was of opinion that with few exceptions any short circuiting of the intestines or intestinal anastomoses might be performed perfectly safely and nearly as quickly by the means he had employed as by bobbins, plates, or buttons.

The patient left the hospital a month after operation, and is now in the enjoyment of fairly good health; the vomiting has entirely ceased and she has gained weight.



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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 20, 1904.

**SIGHT-TESTING BY SPECTACLE-MAKERS.**

THE Ophthalmological Society of the United Kingdom, albeit somewhat late in the day, has made a definite public announcement with regard to the proposed inclusion of sight-testing in the examination subjects for the diploma of the Worshipful Company of Spectacle-Makers. It has issued a report, signed by Mr. John Tweedy, the President, stating briefly the grounds of objection to the proposal in question. The first issue raised is the misleading value of such a diploma, which would induce the public to believe its owner to be competent to diagnose and to treat diseases of the eye. There is no need to point out to medical readers the disastrous consequences that must infallibly dog the footsteps of the unqualified dabbler in ophthalmic work. There is no branch of the medical art that demands greater experience and technical skill than that of ophthalmology. The recognition of the exact nature of the earlier stages of many such affections demands the instant application of various highly specialised methods of scientific investigation. It is precisely in such early cases that a sufferer would be likely to go to an optician, who, armed with just enough knowledge to be dangerous, would waste the precious moments in which the sight might yet be saved by the skilful promptitude of a trained ophthalmic surgeon. The mechanic, for that is the position of the optician when he is not a tradesman pure and simple, cannot be expected to recognise the signs, symptoms and purport of corneal ulcer, opacities of the various media, iritis, gonorrhoeal and other conjunctivitis, detached retina, and glaucoma, to mention a few only of the many urgent conditions that would infallibly come sooner or later under his notice. The thin end of the wedge of the Spectacle-Makers' Company has indeed led to a serious chasm—one that is fraught with danger to the public and

with injustice to the medical profession. As pointed out in the report, errors of refraction often occur in association with diseases of the eye. The mere correction of the former by means of spectacles would ignore a condition which might destroy sight, or even leave the life of the patient in danger. Considerations of that kind, however, are not wont to stay the hand of the amateur in medical matters. The resulting toll of suffering, disease and death paid annually by the inhabitants of the United Kingdom must be something appalling. The efforts of the constitutional law, on the one hand, to protect the people by insisting on proper qualification for medical practitioners is outweighed on the other by the almost absolute licence given to unqualified practitioners and patent medicine vendors. The report properly points out that on general grounds it is dangerous to encourage the public in the belief that affections of any organ of the body can be safely treated by anyone unacquainted with its anatomy and physiology, and with the various morbid conditions to which it is liable. It is to be hoped that the widest publicity will be given to this document. The public need education in the matter, not only of their eyes, but of the rest of their bodies, by the comparison of qualified medical practice with that of quacks. The encroachment of the Spectacle-Makers is but a specimen of what has gone on in a thousand other directions. Any sort of labourer or tradesman may, like the spectacle-maker or vendor, imagine he has the divine gift of healing. The road from the workshop or the tradesman's counter to the consultation room is easy, and the rewards lucrative. Nor is it possible to forget that a medical man has only recently resigned the position of examiner for the diploma issued by the Spectacle-Makers' Company. That gentleman was a member of the Ophthalmological Society, a body that could have put an end to such an anomalous position long since. Had the Society faced that matter squarely and fairly, as it should have done, years ago, their task of convincing the public would not have been so hard as they will find it to-day, when the unpleasant fact of that examinership is thrown in its teeth. The battle of the Ophthalmological Society, however, is that of the medical profession, and, as such, deserves the hearty support of every medical man in the United Kingdom.

**GAS POISONING.**

DURING the past few years members of the medical profession in Dublin have, from time to time, drawn attention to the danger to public health which results from a change in the nature of the gas supplied to the public for illuminant and cooking purposes by the gas company of that city. Up to 1900 the gas supplied was normal coal gas containing the normal 6 per cent. of carbon monoxide, but in February of that year the company altered the nature of the gas by adding a considerable quantity of carburetted water gas. Water gas is made by passing steam over red hot

coke, and is then carburetted by being charged with vapour of petroleum or other inflammable oil. It possesses advantages over coal gas in that it is cheaper and more easily produced to meet an emergency, while, especially when mixed with coal gas, it makes an excellent illuminant. It possesses, however, one very serious disadvantage-- *it contains 30 per cent. of carbon monoxide.* Very shortly after it was introduced by the Dublin gas company, without, be it said, any warning to consumers, Dr. Emerson Reynolds, then Professor of Chemistry in Trinity College, drew public attention to the dangers which might result. He pointed out that in case of accidental leakage of gas, through untrustworthy fittings or otherwise, the danger to life was far greater than when coal gas alone was used. His prediction has been amply verified, for we find that during the past four years no less than ten cases of gas poisoning have occurred in Dublin, with seven fatalities, while in the previous twenty years no case was recorded. Dr. McWeeney has collected particulars of the several cases, and published (a) them in a manner which should focus public attention on a serious danger. In all the cases poisoning followed on an accidental leakage of gas, though in some of them the cause of the leak was difficult to trace. In the first occurrence, for instance, gas was not laid on at all in the premises where the poisoning occurred, but the main in the street outside became broken, and the gas filtered through the soil into the house. Four persons suffered, with one death. In another instance a whole family was sacrificed in a clumsy attempt to defraud the gas company by short-circuiting the meter, and in another an elderly couple from the country, while staying in a city hotel, probably poisoned themselves by blowing out instead of turning off the gas. Again, a young man, apothecary in one of the city dispensaries, was asphyxiated in his bath-room owing to the use of a "geyser," which was probably insufficiently lighted. At present the gas in Dublin contains 16 per cent. of carbon monoxide; up to 1900 it only contained 6 per cent. As small a quantity as .2 per cent. of carbon monoxide in the air is dangerous, and with increased quantities Haldane has shown that the mortality increases as the cube of the increase in the proportion of monoxide. His investigations were made in Boston and Chicago, where the introduction of water gas has been followed by similar results to those that have occurred in Dublin. At present, however, in these countries the public is at the mercy of the gas manufacturers. The sanitary authority in Dublin, which has been appealed to, professes itself powerless to interfere to limit the proportion of carbon monoxide supplied in illuminant gas. If this is so there is urgent need for legislation, but in the meantime we believe the sanitary authority has power to insist that all fittings and gas-cooking apparatus shall be kept in proper order, and that gas mains shall be laid in the street with due care against accidental breakage.

(a) *Dub. Journ. of Med. Sci.*, July, 1904.

#### CENTRAL MIDWIVES' BOARD AGAIN.

THE doings of the Central Midwives' Board since it came into being have been such as to thoroughly justify all that was formerly predicted of the scheme to give midwives official recognition. We lately called attention to some of the ill-judged and over-bearing actions that it has already perpetuated, and showed how those actions were judged by the medical profession. At the last meeting of the Board a motion was brought forward by Dr. Cullingworth that a list of examiners under the Act should be prepared by the Board from those who were willing to serve when required. Dr. Ward Cousins moved a very proper amendment to the effect that no one but a registered medical practitioner should be appointed as an examiner. This amendment, which would have appeared superfluous in the ordinary way, so obviously necessary is it that the examiners should be medical men, was supported by Mr. Parker Young and Dr. Sinclair, but after some debate it was defeated by the votes of Dr. Cullingworth and the three female members of the Committee. This action, we venture to think, for sheer stupidity and offensive disregard of medical opinion, fittingly caps the egregious performances of the Board up to the present time. It is a deliberate and direct slight to the profession of medicine, and it cannot be too strongly resented by those who hold its dignity dear. Medical men have all along been opposed to the creation of a sub-order of practitioners on an independent footing, and it was only out of regard to the welfare of the poor—the question resolving itself into whether they should be attended by trained or untrained midwives—that they abated their opposition, conditionally on the training of these women being left in their hands. The Central Midwives' Board was constituted, and it has persistently endeavoured to show a disregard to all that is deemed essential by medical opinion. But there are limits to this policy, and it seems not unlikely that those limits will soon be reached unless the Board decides to mend its ways. However much it may wish to the contrary, it is only by and with the co-operation of the profession that the Act can be made to work, and if it continues to snub and override the profession it will find that its work may come to a standstill by medical men giving it the cold-shoulder. In the present instance the deliberate opinion of the majority of the Board is that it may be not only possible, but even advantageous, to appoint a midwife to sit side by side with medical men to examine candidates for admission to the register, candidates, be it remembered, who have been trained by medical men. In other words, the Board approve of the principle that a person who has had three months' "training" in midwifery shall sit in judgment on the work of qualified practitioners, and sees nothing incongruous in a professional man acting in subordination to the criticisms of such a person. The medical profession will think otherwise, and, if we mistake not, will show

its aversion in a very practical manner. The specious plea was advanced that a midwife or matron would know about nursing what a medical man would not. Whence, we wonder, have the nursing profession of the day obtained this knowledge in training except from the hands of medical men? The pretext is too flimsy to deserve serious consideration. Nursing is essentially and ultimately a medical question, and the trained nurse is taught, and generally recognises, that she is not an independent professional expert, but an assistant and subordinate to the qualified practitioner. No good nurse wishes to be anything else; she learns enough during her probation to know her own limitations. It is not so with the midwife and those who wish to push her and her practice. The midwife is to act in cases surrounded and attended with anxiety and danger on her own initiative and responsibility, and when she finds things are getting too much for her, to send for a medical man. The exaltation of the midwife and the degradation of the medical man is tacitly the underlying aim of a number of philanthropically-minded people who have interested themselves in the question, and it is an aim which is being fostered and forwarded by the action of the Central Midwives' Board. The doctor is to be ignored as long as possible, and called in—without any provision being made for his payment—when the midwife scents trouble ahead. That is the line taken by the Midwives Act, and the spirit of the Midwives' Board perpetuates the evil tradition. Let the doctors do the training, and the midwives, when they have had the benefit of it, help with the examining and see if the doctors are doing their work properly, forsooth. It is difficult to conceive how a medical man of Dr. Cullingworth's eminence can be found to acquiesce even passively in such a proposition, and we can assure him that Dr. Ward Cousins spoke no more than the truth when he said that he was convinced that the medical profession felt very strongly on the point. If the dangers to the poor entailed by the Act are to be obviated, it is only by leaving the whole question of preparing midwives for their work entirely in medical hands, and enforcing on them that the safety of the mothers and children whom they attend can be attained only by their recognising the vast inferiority of their knowledge to that of the practitioner. Such an end is not likely to be attained by putting midwives to sit cheek by jowl with medical men on examining boards. Dr. Cullingworth has incurred a great responsibility by deliberately voting for the subordination of qualified medical men to mere midwives, and, if we mistake not, he will have sooner or later to be called upon to render an account of his stewardship to the medical profession, to which he owes his position.

### Notes on Current Topics.

#### Beri-Beri as an Epidemic.

IN view of the serious outbreak of beri-beri

among the Chinese labourers in South Africa, our contemporary *Truth* does a public service in recalling the mismanagement shown by the Irish Executive during the epidemic which occurred in the Richmond Asylum, in Dublin, some years ago. The first cases occurred in 1894, and during that year no less than 174 cases appeared, with twenty-five deaths. The disease then apparently disappeared, but recurred in 1896, and in that year, and during the first half of 1897, over 200 cases occurred. From the first the medical staff pointed out to the authorities at Dublin Castle the impossibility of coping with the outbreak while the asylum was as scandalously overcrowded as it was at that time. Of this overcrowding it is difficult to convey an idea, but in most of the dormitories there was barely standing room between the beds, and many of the corridors had to be converted into dormitories by placing a continuous row of beds along the walls. In spite of the continual protests of the medical staff, the Press, and the public, it was not till August, 1897, that accommodation elsewhere was provided for some of the surplusage of patients. We trust that the Transvaal authorities will take to heart the lesson taught in Ireland, though, up to the present, the official telegrams appear of an unwarrantedly complacent nature, and hardly show a due sense of the seriousness of the situation.

#### Spontaneous Rupture in Ascites.

Nor the least complex among the problems of pathology is the mechanism of the production of those peritoneal exudations which, accumulated in any quantity, give rise to the condition known as ascites. The integrity of the portal circulation and the phenomenon of osmosis, in addition to being interdependent, are themselves influenced by other factors about which our knowledge cannot yet be said to be complete. The removal of ascitic fluid by mechanical means is a frequent operation, and the immense relief afforded by a timely paracentesis to a labouring heart is a constant source of satisfaction to the physician. Too often, though, the abdomen fills up again rapidly, necessitating repeated tapplings. In a few instances a gradual absorption of the fluid undoubtedly occurs, especially under the influence of a restricted diet and the application of graduated abdominal pressure. Spontaneous rupture of the abdomen with escape of the peritoneal exudation is an accident which is so rare that the case recently reported by M. A. Cochez (*a*) before the Société Médicale des Hopitaux is worthy of note. The patient was a man of fifty-two, who twenty years ago had contracted malarial fever. The liver then became enlarged. After his recovery he developed alcoholic habits, and three years ago ascites appeared, the liver being cirrhotic. He was tapped frequently, and after the forty-eighth puncture a small vegetation appeared just below the umbilicus. This gave way to a minute patch of ulceration, looking more like

(a) *Bull. et Mem. de la Soc. Med. des Hop.*, Paris, June 23rd, 1904.

granulation tissue. A month afterwards he was again tapped, and a week after this, the forty-ninth paracentesis, ascitic fluid was suddenly ejected through an aperture in the centre of the ulceration during a violent fit of coughing. The abdomen emptied itself completely, and a doctor who was hurriedly summoned closed the opening with collodion. The accident was regarded as a departure from the normal process of peritoneal cicatrisation, which was evidently in progress. M. Cochez considered such a contingency favourable rather than otherwise, as indicating an attempt of Nature towards a spontaneous cure. In the few cases of accidental rupture recorded in the literature, the perforation has nearly always been preceded by a gangrenous ulceration of the abdominal wall, not necessarily connected with the scars produced by puncture.

#### Responsibilities of Nursing Associations.

AN appeal case of considerable importance with regard to the legal responsibilities of nursing associations was decided last week in the London Law Courts. The Oldham Nursing Association sent a nurse to attend at an operation. By her negligence a hot-water bottle was allowed to lie in contact with the bare skin of her patient, who was burnt thereby, and who brought an action for damages. Plaintiff was awarded £300 damages by a jury at Manchester assizes. Defendants appealed on the ground that they were not in point of law liable for the acts of their nurses, who were, they contended, at the time of the alleged negligence, the servants of the lady they were attending. The Master of the Rolls granted the appeal, finding the Association was not liable for any want of ordinary care and skill on the part of the nurse they supplied. For the purposes of nursing the nurse thus sent was in no sense the servant of the Association, which, therefore, was not liable for her carelessness. Medical men should note this judgment. A special contract with the nursing home would tie down a nursing association to a proper responsibility for its nurses.

#### The Doctor in the School.

THE favourable reception which the petition in favour of the teaching of hygiene in schools met with at the Education Office is, in itself, an evidence that the urgent need of such instruction is at least recognised by the Government. The medical profession as a whole was fully represented by the large number of signatories, and such a petition could hardly fail to carry weight with those in authority. But it is not only by the teaching of hygiene and allied subjects by men and women who have been through certain courses of instruction themselves that we can hope to stay the tide of physical degeneration which threatens to submerge the coming race. The need for a qualified medical practitioner to be definitely attached to a school or group of schools has been urged before in the columns of THE MEDICAL PRESS AND CIRCULAR. In connection with this point attention may be

drawn to the most instructive report recently prepared on the Public Schools of Berlin and Charlottenburg by Mr. George Andrew for the Scottish Education Department. In these cities the fact has been recognised that the elementary school is incomplete without the services of a medical man. Wiesbaden was the first place in which the idea was adopted, and in 1901 ten doctors were appointed for this purpose in Berlin. Our own countrymen might well learn some valuable lessons from the newer schools in Charlottenburg, where the school doctor has his own room in the school buildings in which weighing-machines, and instruments for testing vision, &c., are kept. Periodical examinations of each scholar are made from the medical point of view, the parents being present at the first of these; records are taken and kept of the child's physical condition, and appropriate suggestions are made by the medical officer in charge as to diet and school treatment in general. A weekly bath is also given to each scholar, with the exception of the two youngest classes—a most excellent plan, well worthy of imitation. It is sincerely to be hoped that some such system as this will ultimately find its place in every Council school in this country.

#### Ocular Gymnastics.

THE avidity with which medical, or more generally pseudo-medical, details are devoured by the public is one of the characteristic features of the present age. No matter whether bone-setting, pain-killing, or beauty-restoring be the theme, whether it be possible or impossible, plausible or ridiculous, such subjects never fail to attract hosts of the superficial readers and thinkers of to-day. The marvel is that the editors of our newspapers and periodicals admit such articles to their columns. No space would be granted to descriptions of irregular methods of legal practice, for instance; why, then, are accounts of quackery and specious "cures" tolerated? One of the latest of these extravagances is a method for "restoring" sight without the aid of glasses; nay, further, for the painless and expeditious relief of actual cataract without operation. It is well known that the instillation of atropine into the eye will produce considerable improvement in vision in certain cases of cataract, but, of course, this is only temporary. The celebrated "Professor" of the new method does not, apparently, employ even this drug. He contents himself by applying pressure to the globe by means of a special apparatus, which has to be worn at frequent intervals. The explanation of such treatment is said to consist in reducing permanently the antero-posterior diameter of the globe. We are also informed that the blood is the organ of sight, a statement which is indirectly true, but it is difficult to comprehend how an atrophic optic nerve could be made to transmit visual sensations, however greatly increased its vascular supply might become. Massage of the globe is also performed, we presume with a similar

object in view. These gymnastics and "series of pressures" might be fraught with alarming results in conditions, for example, of acute glaucoma. It is a pity that M. De Dion did not confine his attention entirely to his electrical apparatus, in which branch of science he has met with acknowledged success.

#### **Tubercle Bacilli in the Breath.**

IT has generally been held and taught that pulmonary tuberculosis is infectious only through the medium of sputa, and that persons may live in close contact with tuberculous patients without undergoing any risk of infection, so long as they are not exposed to contamination with the sufferers' expectoration. But, like most of the cherished beliefs in medicine, this has been called severely in question, and Dr. Koelzer (*a*) has recently been taking steps to find out if it is not possible that bacilli are exhaled during quiet respiration. His method was to take patients suffering from active tuberculosis of the lung and get them to hold open Petrie dishes before their mouths for varying periods, without coughing or sneezing. He then placed covers on the dishes and examined them by culture and inoculation. Out of fifteen patients so tested he found tubercle bacilli in one dish only, and in that case the patient was suffering from advanced disease with laryngeal ulceration. There is an obvious fallacy about the single Petrie dish. Though one swallow does not make a summer, the result is nevertheless sufficient to make one consider whether Dr. Koelzer's conclusions may not possibly be justified. In his opinion it is possible that during quiet breathing tubercle bacilli may be freed from the muco-pus in the finer tubes by the bursting of the small bubbles produced by air passing through them—those bubbles that one hears as crepitations. The bacilli thus freed may be carried out in the expiratory current, just as they were originally carried in by the inspiratory current. On the other hand, the number disengaged and exhaled in this manner are very few, and probably are not factors of much practical importance in the spread of the disease, but in cases of laryngeal ulceration the numbers are likely to be considerably larger than in cases when the lung only is affected. It seems within the bounds of possibility that Dr. Koelzer is right; at any rate, this side of the question should always be borne in mind in cases where the patient is a husband or wife, and is often in close contact with a healthy person for many hours. It should certainly impress on medical men the duty of insisting that a tuberculous patient should sleep in a room by himself.

#### **The L.G.B. and Tramps.**

THE announcement that the President of the Local Government Board has appointed a Departmental Committee to investigate the subject of vagrancy will be received with great satisfaction by readers of THE MEDICAL PRESS AND CIRCULAR.

(*a*) *Zeits. f. Hyg. u. Infekt. Krank.* Vol. xlv, p. 2.

and by sanitarians generally. Time and again the serious medical aspects of the system by which tramps are allowed to roam the country at their own sweet will have been pointed out in our columns. These "sturdy beggars," as our Elizabethan ancestors would have called them, have been shown to be most potent agents for disseminating small-pox, and there is every probability that variola is only one of the pests for which they are responsible. From the economic point of view, the tramp is not only a disgrace to the community, but he exerts an evil influence on the labouring classes, and without unduly infringing the liberty of the subject it should be quite possible to restrict his activity to a considerable extent. From the medical point of view he should undoubtedly be subjected to the most rigorous supervision and regulation. Dr. Armstrong, of Newcastle-on-Tyne, has been advocating this for the last ten years, showing that more than half the outbreaks of small-pox are originated by the unwelcome presence and habits of tramps, and various authorities have been trying to get the Local Government Board to take the matter in hand. Everything comes to those who wait, and one must not be ungrateful now that this tardy inquiry has been set on foot. It would have been more reassuring had the Committee contained more than one medical man, but here again we must be thankful that Dr. Downes, with his wide experience of Poor-law administration, has been chosen. Let us hope that the inquiry will be thorough and the recommendations unhesitating, for the able-bodied loafer deserves little sympathy, and he has no right to constitute himself a standing menace to the health of useful and industrious people. At the same time, it is impossible to forget that the tramp is a product of society, and that his legal rights to maintenance have been recognised by the law of the land.

#### **Medical Men and Drink Legislation.**

THE drink question has recently been laid before the public in all its various bearings by the licensing proposals of Mr. Balfour's Government. There can be hardly any one great social question on which the medical profession is better qualified to speak with the voice of authority. The National Church has spoken with a somewhat wavering voice upon the matter, but on the whole its support of temperance interests has been emphatic. Why should not medical men speak out their collective mind as to whether Mr. Balfour's alterations in licensing law are likely to increase the facilities for drinking amongst our countrymen or the reverse? The fact that alcohol lies at the bottom of a vast mass of disease, crime, misery, and avoidable suffering amongst mankind is brought home daily, nay, hourly, to the medical man. Why should he not proclaim his opinion without regard to politics or creed, to brewers or any other class upon a point that touches more or less nearly the happiness of every man, woman, or child in the United

Kingdom? That the medical profession is able to take such a step was shown by the petition signed by 17,000 medical men and presented to the Education Department with a view of rendering the teaching of hygiene compulsory in State schools. There is little use, however, in allowing our labouring classes to sap their manhood and bequeath a broken constitution to their offspring, and then to trust to school lessons to mend matters. Regulate the parents' drink first, and teach the children afterwards. Begin at the foundation.

#### Caisson Disease.

EVER since it has been the custom to dig in the bowels of the earth in atmospheres of high pressure, something has been known of the condition which at present goes under the name of "caisson disease." The symptoms, which come on after the release from the high pressure chamber, are various, and, at first sight, quite disconnected. One of the commonest is a colicky pain which has given the disease its nickname of the "bends" among American workmen. Sometimes the joints swell, and there may be a violent pruritus, known in the vernacular as "fleas." Sharp muscular pains are common, and more serious symptoms are stupor, anæsthesia, coma, deafness, blindness, sudden death. It has been noticed that the symptoms do not occur if the period of decompression be gradual and prolonged, and with this precaution very high pressures can be borne without injury. The only treatment which has ever been effective is an immediate return to a high pressure, followed by very gradual decompression. The pathology of the condition was for long ascribed to minute hæmorrhages occurring in the spinal cord and elsewhere, but this view is now abandoned. The researches of Hoppe-Seyler, Paul Bert, and others showed that the true cause was the sudden return of the gas dissolved in the blood and tissues to the free state, owing to the sudden relief of tension. During the period of pressure, the blood, like the fluid in a closed soda-water bottle, contains large quantities of gas in solution; on the pressure being diminished, ebullition occurs, just as when the cork is drawn from the bottle. The chief gas concerned is nitrogen, for the absorption of oxygen is but little altered by atmospheric pressure, and that of carbon dioxide not at all. The frequency of the disease during engineering operations in America is becoming somewhat of a scandal, and as it can absolutely be avoided by reasonable care, it is time that the authorities should step in and insist on the necessary precautions being taken.

#### A Faith Cure by Fire.

A DRAMATIC episode was given last week by the *Daily Chronicle*, of a cripple who suddenly recovered the use of his limbs. The account relates to one Pat Shay, who for four years had suffered from paralysis of the legs, which compelled him to walk about on crutches. One night he saw fire issuing from a shop in Seven Dials, London. With the help of another man

he burst open the door, and then, flinging away his crutches, he dashed upstairs and brought down a baby. The two men between them rescued the rest of the inmates. This case appears to the *Chronicle* writer, as it would to the ordinary man in the street, in the light of a miracle. If the paralysis were muscular, due to peripheral neuritis, there is nothing surprising in the recovery. The "cripple" had most likely been using crutches for some time when he might have walked. Suppose this man Shay had been under the notorious "miner" surgeon or other unqualified person, the full credit of the "cure" would have been acquired in a case where cure was not needed. In a great proportion of instances it is from sufferers of this type that bone-setters and quacks gain their successes. Obviously the man Shay was perfectly honest in the belief that he was unable to walk until the fire showed him the contrary. The crippled British public, however, are not likely to resort to fires to test the reality of their disablement, although, from the point of view of the medical profession, they act little less foolishly in trusting to cancer-curers, faith-healers, unqualified electricians, bone-setters, herbalists, and the rest of the harpies that batten on the life blood of their credulous victims.

#### Formalin in Milk.

THE medical superintendents of the Poor-law infirmaries have been acquainted for some years past with a form of skin disease that occurs in epidemic form at irregular intervals. Savill was the first to describe such an outbreak, and on each occasion there has been reason to suspect milk as the causative agent. Last September one of these epidemics attacked the inmates of the Central London Sick Asylum at Hendon, and Dr. Monckton Copeman was sent by the Local Government Board to investigate and report. The recently published account of his inquiry shows that sixty-eight persons were attacked and that two died, and although this is a lower mortality than usual, it is sufficiently serious. Acting on the supposition that the milk supply was at fault, the patients were all put upon Swiss milk, and from that date they all began to recover. Attention was attracted to the fact that the original milk remained sweet for a long time, and this observation led to a search for preservatives in it, a search that revealed the presence of formalin. In the absence of any well-established action of formalin on the skin it cannot be demonstrably proved that this antiseptic was the etiological factor, but there being no other likely cause, the probability of formalin, or some product of delayed fermentation through its action on the milk being at the bottom of the trouble cannot be lightly disregarded. The subject deserves the earnest attention of sanitarians. The policy of putting preservatives in milk is a vicious one, and the difficulty of securing convictions against those who do so is

great, for the defendants in an action can nearly always call expert evidence to show that nothing certain is known on the subject. If it could be established that formalin has the power of setting up a condition of the kind that occurred at Hendon, the strongest measures would be justified with a view to putting down the unwholesome practice. During the present hot weather formalin solution is doubtless being drunk by the gallon by men, women, and—worse still—by children, and with Hendon's experience before our eyes, we cannot regard the prospect with equanimity.

#### Exit the Slate.

THE slate, with all its associations and traditions, is doomed, and in the course of a generation or so it will be as extinct as the dodo. The light of hygienic truth is slowly filtering through the red-tape barriers of the Board of Education, and for such fitful gleams as gain access to the recesses of its pigeon-holes we must be duly thankful. The facts that slates form a convenient medium for the transfer of pathological organisms from one child to another, and that the licking of slates, affording as it does the easiest and most ready method of deleting mistakes, is a dirty and insanitary habit, have often been pointed out. But custom is hard to break with, and no one in authority has yet had sufficient initiative to attempt to replace the old-fashioned slate by the obviously more convenient and cleanly substitutes—paper and pencils. Perhaps the future school-boy, with his smiling morning face, will go even more unwillingly to school when he knows that he will be deprived of the amusement of drawing portraits of his master that can be crased with a dab of saliva should the dominie's eye travel in his direction, but it is likely that his absences from school will not be so frequent when this hoary institution is relegated to the limbo of things forgotten. Lord Londonderry has not shown himself a brave or vigorous administrator since he went to the Board of Education, and there is plenty of room for well-directed zeal in his present post, but this little reform will serve to show that he is not altogether without imagination. We wish he could have given a more decided and encouraging answer to the medical deputation that waited on him last week to urge that elementary hygiene should form part of the ordinary school curriculum, but in the meantime we must take the abolition of the slate as a hostage for good intentions for the future.

#### PERSONAL.

ON July 15th, his Majesty the King visited Newmarket Workhouse, and after inspecting the hospital wards, made the following entry in the visitors' book: "It is nine years since I visited this union, and I find it vastly improved and in excellent order."

It is announced that Princess Victoria of Schleswig-Holstein, the eldest daughter of Prince and Princess

Christian, has been operated upon for appendicitis at the Prince Victoria Memorial Home, Windsor. The accounts of the progress of the Royal patient are satisfactory.

DR. WILLIAM MURRELL has been appointed Examiner in Materia Medica in the University of Glasgow.

M. A. CHAUVEAU has succeeded the late distinguished physiologist Professor Marey in the Directorship of the Institut Marey.

HIS MAJESTY has approved the appointment of Sir William MacGregor, M.D., K.C.M.G., C.B., at present Governor of Lagos, to be Governor and Commander-in-Chief of Newfoundland, in succession to Sir Cavendish Boyle, who has been appointed Governor of Mauritius.

At a quarterly meeting of the Council of the Royal College of Surgeons of England, Mr. John Tweedy was re-elected President for the ensuing year, and Mr. A. W. Mayo Robson and Mr. Henry T. Butlin were elected Vice-Presidents.

THE President of the Local Government Board, after consultation with the Home Secretary, has appointed a Departmental Committee on Vagrancy, consisting of the Right Honourable J. L. Wharton, M.P. (Chairman), Sir William Chance, Mr. J. S. Davy, C.B., Dr. Downes, Captain Eardley-Wilmot, Captain Showers, and Mr. H. B. Simpson, with Mr. F. L. Turner, of the Local Government Board, as Secretary.

ON the 14th instant, Mr. Sydney Stephenson presided over a large and distinguished gathering at the Hotel Cecil on the occasion of the annual dinner of the Society for the Study of Disease in Children.

MR. JOHN TWEEDY, President of the English Royal College of Surgeons, has revived the annual dinner of the Fellows of that body, and presided at the first dinner held on the July 7th, under the new arrangement in the Library of the College.

It has been proposed by the Berlin Committee for Cancer Research to found a special department in the new buildings of the Charité for the study of that malady under the direction of Professor von Leyden.

DR. E. MODDER, Assistant Colonial Surgeon, Ratnapura, Ceylon, goes to Kalutara in place of Dr. Spittal, who is now medical officer of Colombo.

PROFESSOR VON ESMARCH, of Kiel, has just met with a serious accident by falling out of bed and breaking his collar-bone. In spite of his advanced age his condition is said to be satisfactory.

THE list of the Honorary Medical Staff of King Edward VII.'s Hospital for Officers has been gazetted, the appointments being for five years from January 1st, 1904. Consulting Surgeons, Sir Thomas Smith, Bt., K.C.V.O., F.R.C.S.; Sir Frederick Treves, Bt., K.C.V.O., C.B., F.R.C.S., and a staff of twenty-five other well-known physicians and surgeons.

### Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]  
SCOTLAND.

SLANDER ACTION AGAINST SIR PATRICK HERON WATSON.—Judgment was given on the adjustment of the issues of this trial on the 12th inst., and notice of appeal has been lodged. Mrs. Jones or McEwan sues for two sums of £2,500, and Mr. Jones, her father, for £2,500. The issues proposed by the pursuers were to the following effect:—(1) Whether in October, 1901, the pursuer employed the defender as her confidential medical adviser to advise her as to her state of health, and in the matter of an action for judicial separation about to be instituted by the pursuer against her husband, and whether the defender, in breach of his



confidential employment in October, 1903, disclosed to pursuer's husband, his law agent, and the counsel engaged on his behalf to defend the action for separation, matters relative to the pursuer's health ascertained in the course of the said confidential employment. (2) Whether at the trial of the separation case the defender, in breach of his confidential employment, voluntarily gave evidence on behalf of Mr. McEwan, and disclosed matters relative to the pursuer's health, to her detriment. (3) Whether in October, 1903, the defender falsely and calumniously stated to Mr. McEwan, his agents, and his counsel that in October, 1901, the pursuer was bent on inducing premature labour so as to free her of any permanent reminder of his marriage. (4) Whether in October, 1903, defender voluntarily made a similar statement in open court in her evidence as a witness on behalf of Mr. McEwan. For the defence counsel contended that as regards the first issue, the alleged breach of confidence, being a disclosure in the course of precognition was privileged equally with testimony given in the witness-box. The whole case turned on the question of privilege, and absolute privilege with regard to a witness' statements in the box was in the interests of the public. If defender was entitled and bound to give the evidence he did in the witness-box, and was absolutely privileged, he could not be held liable for the relative precognitions. Moreover, the pursuer was not entitled to divide the wrong from which she said she had suffered into two parts and claim damages for each—for the alleged slander and the alleged breach of confidence. There was no allegation that the notes which the defender produced at the trial were other than genuine notes of his impressions two years previously, and how a gentleman producing such notes could be accused of acting maliciously counsel could not understand. In any case, even if his lordship should allow of issues, he asked that the case should be tried without a jury. For the pursuer, Counsel stated that the defender was not only in the position of an ordinary confidential medical adviser, but was confidential adviser in regard to a proposed litigation. It was common ground between the parties that Dr. Watson's opinion after he had examined the pursuer was adverse to her, that he was not asked to give evidence on her behalf, that pursuer's agents got intimation that the defender was to examine her on behalf of her husband and as a proposed witness for him in the action for separation, and that the pursuer's agent had brought pointedly before Dr. Watson, before he made his second examination of Mrs. McEwan, that he had previously been employed by her confidentially in connection with that very action. It was also common ground that the defender disclosed to Mr. McEwan not only results of his second examination, but the results of the first, including the contents of the notes. As to precognition being privileged, no one could force a witness in precognition to say anything, and had the defender adopted that course nothing would ever have been heard of it, because it was quite evident that the husband would never have called him as a witness without knowing what he was going to say. Lord Kincairney, in giving judgment approved of issues (1) and (3). After reviewing the circumstances under which the action arose, he said that though the pursuer stated that the defender's statements were made maliciously, there was no averments from which malice could be inferred, and the idea of actual malice seemed preposterous and not in the case at all. The defender pleaded against the duplication of issues, but he saw nothing objectionable in this, there being a sufficient difference in the time and circumstances in which the words objected to were spoken, in private and at the trial, to warrant a separate issue for each occasion. Further, it seemed legitimate to put breach of confidentiality in one issue and defamation in another, as one issue might fail, and the other succeed, or the damages might be totally different in the two cases. There were, therefore, four issues to be disposed of. He had little difficulty in disallowing the fourth—an issue for defamation for evidence given in court on oath. Nothing was more

clearly settled than that in such a case the protection of a witness was absolute, whether his words were true or false, *bona fide* or malicious. He saw no ground for disallowing the third issue; the pursuer did not say that it referred to the precognition of the defender by pursuer's husband, and he did not see that that could be assumed. Even if it were, however, he had no doubt, that no absolute privilege attached to words spoken in precognition, and he was not prepared to say that they were privileged at all. He did not think malice could be added to that issue. The second issue was covered by the principle which afforded absolute protection to a witness, and was disallowed. The greatest difficulty was as to the first issue, but he thought it must be allowed. There seemed to be no other Scottish authority than a case in 1851, which was, however, quite conclusive, and, sitting in the Outer House, he considered he must follow it. The judgment applied to the action of Mr. Jones, the issues in his case being the same as in Mrs. McEwan's, except that the issue as regards confidentiality was omitted.

### Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The question of the diminishing birth-rate, which is so universal in almost all civilised European States and in English-speaking colonies, is, in my opinion, the greatest question in the domain of hygiene.

Notwithstanding the interesting statistics put forward in your issue of July 13th, by Dr. David Walsh, I think it is now well ascertained that, in the words of Dr. Billing, late Registrar-General of the United States, the recent fall in the birth-rate in civilised States or its most important cause is "the deliberate and voluntary prevention of child-bearing on the part of a steadily increasing number of married people, who not only prefer to have few children, but know how to attain that wish." Dr. Billing's views are readily seen to be true for the cities of the United States, for the "Statesman's Year-Book of 1902" mentions that the birth-rates per 1,000 persons in 1900 were, in New York, 22'50; in Chicago, 17'11; in Philadelphia, 20'50; in Saint Louis, 18'12; in Baltimore, 15'79; in San Francisco, 14'75; and in Cincinnati, 17'26. Compare these low birth-rates with that of London, 28'5; and recollect that in New Zealand, confessedly the most prudent of all countries in its birth-rate, where the birth-rate has fallen since 1880, when it was 40 per 1,000, to 26 per 1,000 in 1900, and Dr. Walsh may perhaps confess that Dr. Billing's account of the diminishing birth-rate is the true one. Ireland is an exception, for there, curiously enough, the marriage-rate is extremely low, whilst the births to each marriage are very high. I conclude that this is due to the power of the Catholic priesthood in Ireland, which is so diminished in France that a Bishop of that church lately had to petition the Vatican to forbid French priests to threaten communicants with censure who employed the methods referred to by Dr. Billing for keeping their families within their means of feeding them.

This new view of family life dates from 1877, when the important case of *Reg. v. Bradlaugh and Besant* came before the courts, and when I gave evidence for the defendants. In London, since then, some districts show a notable diminution in their birth-rates. Hampstead and Kensington, which in 1877 had birth-rates of over 35 per 1,000, have at present birth-rates of from about 18 to 20 per 1,000 inhabitants; while indigent districts, such as St. George's-in-the-East, have birth-rates of over 40 per 1,000. Now, high birth-rates in our cities mean high infantile mortality and crowding into purlieus like those of London, Dublin, Manchester, and Glasgow. The death-rate from phthisis, for instance, is six times as high in the poor streets of Brussels as in the wealthy classes living near

the park of that city, according to the late Dr. Janssens. I notice that Dr. Taylor, of Birmingham, thinks that the health of the wife is likely to suffer if she has only three or four children or less. But, of course, infinitely greater danger to the health of mothers and children is caused by large families when wages are low. In the Metropolitan Free Hospital, when it was situated in Whitechapel, I found that 100 married women over the age of forty-five had produced 720 children as a rule; and of these more than half had died in early childhood. On the other hand, Dr. Lutaud, of Paris, has shown in a letter to Mr. Hausmeister, of Stuttgart, that the wives of 100 medical practitioners of Paris gave birth to only 150 children—*i.e.*, to less than two children to a marriage. I found a similar state of things to exist in 1878 when I made an inquiry among French medical men on this point.

I submit to Dr. Taylor that the excellent physicians and surgeons of Paris cannot believe with him that small families are very hurtful to the health of their wives; but even were there a good deal of truth in his views it would be a remedy far worse than the disease to recommend more children to persons already overburdened with the care of those they were responsible for. I may perhaps, add that the health of children could not suffer from parental prudence if the three children required were born in the early years of the marriage. As to men, French physicians totally deny any injury done to their health by the innocent means they adopt to keep their families within their means of educating them. Marriage (*pace* the Catholic Church) is far more hygienic than singleness, which, as Sir Benjamin Brodie once said, produces "so many evils that he could not mention them, but which were even greater than the evils caused by prostitution." I presume he referred to masturbation and melancholia, etc.

Economically, however, it is out of the question for the people of any European State like ours to think of having large families with impunity. The censuses of the United States give us a clear proof of the population law, so well explained in 1798 by the great economist T. R. Malthus; for, in the year 1800 the population of the States was 5,308,000 and in 1830, 12,866,000; that is, it far more than doubled in thirty years, although between 1800 and 1830 there was scarcely any immigration from Europe into the States. Since 1800, while the inhabitants of the United Kingdom increased from 16,345,000 to 41,605,000 in 1901, or only about two and a half times in a century, the population of the United States increased from 5,308,000 in 1800 to 75,820,000 in 1900, or about fifteen-fold in that century.

The evident deduction from these facts is that we, in old countries like ours, must check population somehow, voluntarily or involuntarily; and the only question we have to solve is this—What is the least painful check we can devise? War, pestilence, and famine are intolerable; late marriages painful, and productive of prostitution and venereal contagion; emigration a delusion, as it removes one sex to the colonies and leaves the other in Europe, and because it tends to make people trust to a broken reed, besides becoming yearly more and more unattainable. Experience shows that we are even more crowded—as are the Germans—than ever with all our colonisation.

Hence we are now in the position to confess that we had better make up our minds that the best check to population consists in the producing—by *all* classes—whether rich or poor, of very restricted families such as four children as a maximum, or perhaps three or less on an average to each married couple, even although that restriction may occasionally be thought to slightly deteriorate the health of a few. "Of all evils choose the least" is the only true philosophy of the *homo sapiens*, and morality means for us moderns that conduct which tends towards minimising the preventable sorrows of our race. I am, Sir, yours truly,

C. R. DRYSDALE,

Consulting Physician to the Metropolitan Hospital of London.

### THE LUNACY QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—What we want to do now is to arrange properly between doctors, lawyers, lunatics, and their friends or relatives. Doctors a few years ago were afraid to sign certificates, after the case of Weldon *v.* Whislow and Semple, and many feel now that they run risks in signing, even in undoubted cases. Where there is the least doubt no medical certificates can be obtained. When it was possible for a patient to be taken off to an asylum on the simple showing of two doctors' certificates, and nothing more, cases of malpractice did occur. Lunatic asylums were not nice places and Charles Reade showed them up.

Thank goodness, "tempora mutantur"; but how much of this is due to the medical profession is not very clear. Mrs. Weldon did some good, perhaps, but Dr. Semple's friends felt sorry for him. All that a doctor should be asked to do is to give a certificate of the mental condition of the case, much in the same way that he does of the physical, when filling up a form of insurance. There should be no doubt in the minds of friends, relatives, or lawyers about the doctors' perfect honour and honesty, and in this the readers of THE MEDICAL PRESS will agree.

I am Sir, yours truly,

R. L.

### THE MIDWIVES' INSTITUTE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In accordance with the request contained in the paragraph in your issue of 14th instant headed "The Midwives' Institute," we are instructed to say that the Incorporated Midwives' Institute never has been in any way connected or affiliated with the Midwives' Society referred to in such paragraph and consequently has not been absorbed in such Society. We are also instructed to request that you will, in your next issue, give publicity to this letter.

I am, Sir, yours truly,

BROWN, RINGROSE & LIGHTBODY.

18th July, 1904. Abingdon Street, London, S.W.

[We have much pleasure in inserting the above statement.—Ed.]

### THE ANNUAL TEMPERANCE BREAKFAST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you kindly allow me to invite the attention of the profession to the Annual Temperance Breakfast which will be given by the National Temperance League at Oxford, on Thursday morning, 28th inst. The occasion will this year be of exceptional interest, in view of the recent memorial to the Educational Department, and of the evidence which we were enabled to present to the Physical Deterioration Committee of the Privy Council. I shall be glad if those who can attend will kindly apply for tickets at our table in the Reception Room.

I am, Sir, yours truly, JOHN TURNER RAE, Sec.

### Presentation to Professors Coffey and Ryan.

LAST week the governing body of the Catholic University School of Medicine with many of the past and present students met for the purpose of presenting two of the professors, Drs. Coffey and Ryan, with tokens of friendship on the occasion of their approaching marriages. Sir Christopher Nixon, Dean of the School presided, and while regretting that his colleagues' devotion to service would not in future take first place in their affections, he expressed the "respect which all entertained for their intellectual attainments, the admiration felt for their high personal character, for their unassuming charm of manner in itself an attribute of genius, and for their kindness of manner, which enforced the affection of all, colleagues, professional brethren, and students." Addresses were read to both gentlemen by the secretary of the Students' Committee and replies were made. Many scientific workers, to whom the labours of Dr. Coffey and Dr. Ryan in physiology and chemistry respectively have made them known, will join in the good wishes they have received from their immediate associates.

**Obituary.**

DR. W. A. M'KEOWN, BELFAST.

It is with great regret we record the death of William Alexander M'Keown, of Belfast, one of the best-known medical men in the North of Ireland. Though in indifferent health for some time, a serious result was not expected, and his sudden death on the 9th inst., was a shock to many. He was about sixty years of age, and had been in active practice as an ophthalmic surgeon since 1870. In this branch of surgery he made some notable advances, which are invariably connected with his name. Of these the most important were the introduction of the use of the magnet for the removal of metallic bodies from the eye-ball, and more recently his operative treatment of immature cataract. At the time of his death he had just accepted an invitation from the authorities of the Johns Hopkins Hospital to pay a visit to Baltimore, and demonstrate his method of procedure in this operation. He was intimately associated with all medical organisations in the North of Ireland and had been President of the Ulster Medical Society as well as of the North of Ireland Branch of the British Medical Association. Outside his surgical work, Dr. M'Keown was well known on account of the keen interest he took in all educational matters. On most points regarding the thorny subject of Irish education, primary, intermediate, and university, he held strong convictions, and he took care that they were known. Of vigorous courage and honesty of purpose, he was an acute controversialist, a hard hitter, and a good fighter. He was fixedly opposed to denominational education of every kind, and was, in consequence, a strong opponent of any scheme for the establishment of a Roman Catholic University in Ireland, while at the same time his objection to the clerical management of schools often brought him into conflict with the ministers of his own—the Presbyterian—Church. Not only by his professional brethren and the public of the North of Ireland is his death deplored, but by all those with whom, whether as ally or as opponent, he was brought into touch in public life.

GEORGE WILLIAMS PARKER, M.R.C.P.  
LONDON.

A CABLEGRAM from Georgetown, British Guiana, states that Dr. G. W. Parker, who arrived there from London in February in order to make collections of plants for Kew, and medicine plants for the British Pharmaceutical Society, has succumbed to an attack of malaria. Mr. Parker was cruising on a steam yacht when he was seized with fever. He was brought on shore in an unconscious condition, and died four hours later. Dr. Parker was formerly Court physician to the Queen of Madagascar. He was educated at St. Thomas's Hospital, London, and took the L.R.C.P. Lond. in 1872, the M.R.C.P. Lond., in 1883, and M.R.C.P. Edin, in 1878.

GEORGE ALDRIDGE GEORGE, M.R.C.S., L.R.C.P.

We regret to record the death, at Bournemouth, of Dr. G. A. George, formerly of Dorchester. He had been suffering for some time from diabetes, and on Monday week went to London to consult a specialist. He was the eldest son of the late Mr. Josiah George, Jun., of Romsey, a well-known brewer. He himself early in life had experience of banking, and was for a time manager of a branch bank in India. The failure of that banking business turned his attention into another channel—the main channel in which the current of his life thereafter flowed. Coming back to England, he resolved to study for the medical profession, and entered University College Hospital, London, where he passed as Licentiate of the Royal Colleges of Surgeons and Physicians in 1877.

**The Cholera in Persia.**

ACCORDING to a *Times'* telegram, the mortality from cholera in Persia is gradually decreasing, but there are still over 200 deaths daily. The districts surrounding Teheran are suffering severely.

**Laboratory Notes.**

BOVININE.

THE place of invalid restorative foodstuffs in the sick-room is now one of the commonplaces of medical practice. We have pleasure, therefore, in giving the following analysis of one of the best known of these products. A sample obtained by us yielded the following results:—

Total solids, 21.1 grammes per 100 c.c.

Mineral matter, 1.5 " " "

This mineral matter contained a little common salt, and the remainder appeared to be almost entirely phosphate of calcium.

The total solids, or residue left on drying, was almost entirely of a nitrogenous nature, and an estimation by Kjeldahl's method showed the sample to contain 18.2 grammes per 100 c.c. of albuminoids. As it was found that the preparation coagulated on heating, it appears to be a meat juice prepared by the cold process. We are opinion, considering the above facts, that this preparation should be of high nutrient and stimulating value, and we therefore have pleasure in commending it to the notice of our readers.

**FRIEDRICHSHALL.**

FRIEDRICHSHALL now enjoys a classical reputation in the field of medicine. This natural mineral water is described as a "pleasant, mild, and certain aperient." We are able to testify to this from personal experience, and a use of it extending over some years has confirmed the good opinion we have always held of it.

Its action depends on the sulphates and chlorides of sodium and magnesium that it contains, and we have now again analysed it with results that differ very slightly indeed from an analysis we made some years ago. The composition of the water is roughly as follows:—There are about two and one half per cent. of solids, which consist of the sulphate and chlorides of sodium and magnesium.

The taste is far from disagreeable, considering the amount and character of the salts present. However it is to be explained the fact remains that the mineral salts naturally occurring in waters of this character are more efficacious and less unpleasant to take than solutions of the same salts artificially prepared.

**ANGOSTURA BITTERS.**

WE have examined a sample of this well-known brand of bitters procured from the original manufacturers, Messrs. J. G. B. Siegert and Sons, and consider that the results we have obtained in the laboratory, combined with a practical experience extending over more than ten years, justify us in stating that the claims made for it by the makers are in no way exaggerated. As many imitations of these well-known "bitters" are put up by chemists and other manufacturers, some of which contain cinchona preparations and various kinds of bitter principles, it is obvious that a standard preparation compounded by the original makers is much to be preferred to fictitious imitations. The original preparation has frequently been examined and approved by well-known analysts, and in the present case we have ourselves carefully analysed and searched for all possible deleterious substances and have found them entirely absent. The preparation contains alcohol to the extent of about 50 per cent. of absolute alcohol, and about 6 per cent. of solid residue, and only 0.5 per cent. of mineral matter, which shows that the bitters are purely vegetable in their composition.

**Literary Notes and Gossip.**

"THE Queen Newspaper Book of Travel" (London: Horace Cox, 1904. Price 2s. 6d.), is a dainty little volume, handy in shape, concise in matter, eminently practical in service, and is a *resumé* of travel information that has appeared in the pages of the *Queen* from 1894 up to the present year. Useful particulars of various health and holiday resorts in the United Kingdom, Europe, and even Africa, are given, arranged in

convenient alphabetical form. It is evidently a guide book for the wealthy traveller, but also contains hints and suggestions which should be of value to many a physician when selecting a suitable resort for his patients. \*\*\*

WE understand that Dr. Ralph W. Leftwich has thoroughly revised his "Index of Symptoms," of which a third and considerably enlarged edition will be published by Messrs. Smith, Elder and Company immediately. The last edition had a somewhat bald appearance from the multitude of unbroken columns. This has been remedied by breaking up the last chapter on "Methods of Diagnosis," and inserting its different parts under their respective headings. \*\*\*

THE Royal Statistical Society announces that the subject of the essays for the Howard Medal, which will be awarded in 1905, with £20 as heretofore, is "A Critical Inquiry into the Comparative Prevalence of Lunacy and other Mental Defects in the United Kingdom during the last Fifty Years." \*\*\*

"THE Seaside and Inland A B C Holiday Guide" (London: Wentworth Publishing Company), is a well-arranged, concise, but somewhat scantily illustrated handbook of useful information for tourists and holiday seekers, which should prove of much service to those desirous of readily gaining trustworthy information regarding many of our British health stations. Medical men will find this little manual useful for purposes of rapid reference. \*\*\*

"WHERE to Stay" (London: The Gordon Hotels, Limited) claims to be the official guide to the best hotels in the United Kingdom and abroad. It is an excellent alphabetically arranged illustrated guide, which should prove invaluable to travellers; and physicians having to advise patients in the choice of desirable residential quarters in various health resorts would do well to have a copy of this little work within reach. \*\*\*

New editions of two important standard works have just made their appearance—viz., a fourth edition of Dr. Dawson Turner's "Manual of Practical Medical Electricity," and a second edition of Messrs. Robson and Moynihan's "Diseases of the Stomach and their Surgical Treatment." In the former, Röntgen rays, Finsen light, radium, and High-frequency currents receive fuller treatment, and thirty fresh illustrations have been added; and in the latter volume the authors state that "the whole work has undergone most careful revision," and many new illustrations have been added. Both works are issued by Messrs. Bailliere, Tindall and Cox. \*\*\*

THE *Journal* of the Royal Army Medical Corps, edited by Colonel David Bruce, F.R.S., R.A.M.C., contains many papers of scientific and literary excellence. Among the articles may be specially noted those on "Enteric Fever" by Captain E. Blake Knox, R.A.M.C., and by Captain W. S. Harrison, R.A.M.C. The former deals with the spread of enteric fever by urine and its prophylaxis, and the latter with our present position with regard to enteric fever in India. These papers are of value in attacking the ever-present problem of enteric fever in India. A paper on "Sleeping Sickness in Uganda" is contributed by Colonel Bruce. \*\*\*

NURSE GOLDIE'S "Notes on Home Nursing," is a useful repertory of practical hints compiled for the benefit of untrained persons who are called upon to render first aid in emergencies or nursing assistance to the sick in their own homes. In such a small volume the author could not possibly attempt to systematise, but she has managed to touch on all the points likely to be of interest to the general reader. We have our doubts as to the utility of giving directions for bandaging without the help of illustrations, but in such a dainty volume really there is no room for the latter. In short, these "Notes" constitute a very handy portable work of reference for family and general use. \*\*\*

A PAPER of considerable importance was communicated at the last meeting of the Royal Society by Sir Thomas R. Fraser, M.D., F.R.S., of Edinburgh, and Major R. H. Elliot, of the Indian Medical Service, who have been conducting a research into the action of snake venoms. They find that the most deadly of all substances of this nature which they have examined is the venom of the sea-snake, *Enhydrina valahadiensis*—resembling, but more lethal than, that of the cobra. This sea-snake has, of course, nothing to do with the so-called sea-serpent, and is chiefly found in the Indian Ocean. \*\*\*

#### Society for the Relief of Widows and Orphans of Medical Men.

At the quarterly Court of Directors of this Society held on Wednesday last, the President, Mr. Christopher Health, being in the chair, two new members were elected, the deaths of three members reported, and two gentlemen had ceased to be members of the Society. A grant at the rate of £50 per annum was made on the application of a widow. The deaths of two widows were announced; one aged 81, had been in receipt of grants since January 1877, and had received £1,540 from the Society, her husband had only been a member ten years, paying 20 guineas; the other, who had just entered her 101st year, had received £1,245, having been on the funds of the society since January 1882, the husband had paid 32 guineas subscriptions. The death of an orphan was reported, who had been on the Copeland Fund since 1866, and had received £452. A legacy of £1,000 had been paid by the executors of Mrs. Du Pasquier. The expenses of the quarter amounted to £52 12s. 6d. \*\*\*

#### Royal University of Ireland.

THE examiners have recommended that the following candidates be adjudged to have passed the First Examination in Medicine, Summer, 1904:—John B. Aickin, Thomas P. Carroll, James K. P. Clarke, Michael Connell, Victor L. Connolly, Gertrude C. Corscadden, Nicholas Cunningham, George Deery, Elliot P. Dewar, Charles Dickson, William P. Dunne, B.A., Michael P. Fitzgerald, Hugh J. Grant, Edmund J. Harty, Joseph Horan, John C. Johnson, Thomas Kennedy, Peter J. Keogh, Joshua Keyms, Alan Kidd, William C. M. Lewis, William P. MacArthur, Samuel W. M'Combe, Thomas C. MacGowan, Mathew J. M'Grath, Michael M'Niff, Henry H. MacWilliam, Patrick J. Mockler, Kenneth F. Mulligan, Ulick J. G. Mulligan, Daniel F. Murnaghan, Harris Newman, Peter H. O'Connell, William M. J. O'Connor, William D. O'Kelly, William F. O'Regan, Alexander Patton, John F. Rahilly, Alfred H. Rentoul, Robert H. Robinson, John A. Sinton, William Speedy, Robert S. Taggart, Gerald J. W. Tierney, William Tyrrell, Bruce A. West, John M. Williams, Joseph A. L. Wilson. \*\*\*

The undermentioned candidates have qualified on their answering to present themselves for the further examination for Honours in the subjects set after their names. Those qualified in two or more subjects may present themselves for the Honour examination in all subjects:—James K. P. Clarke, zoology; Charles Dickson, chemistry; William P. Dunne, B.A., zoology and physics; Michael P. Fitzgerald, botany; Hugh J. Grant, chemistry and physics; John C. Johnson, botany, chemistry, and physics; Joshua Keyms, physics; Alan Kidd, botany; William C. M. Lewis, chemistry and physics; William P. MacArthur, chemistry; Henry H. MacWilliam, botany, zoology, chemistry, and physics; Kenneth F. Mulligan, botany, zoology, chemistry; Peter H. O'Connell, physics; William D. O'Kelly, botany, zoology, chemistry, and physics; Alfred H. Rentoul, botany and zoology; Robert H. Robinson, botany and chemistry; John J. Sheil, physics; John A. Sinton, botany, zoology, and physics; Bruce A. West, botany and physics. \*\*\*

The examiners have recommended that the following candidate be adjudged to have passed the examination for Diploma in Sanitary Science:—Dennis J. Collins, M.B., B.Ch., B.A.O., Royal Army Medical College, London. \*\*\*

## 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, 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.

THE *Dail Chronicle* states that last week near University College Hospital, the body of an infant was found wrapped in paper, on which was written: "To the Professor of Anatomy, Middlesex Hospital."

T. P. O'CONNOR, in his *Weekly*, quotes the following verses anent a notorious quack of the last century from the "Epitaph on a Fair Patient of St. John Long's." "St. John Long was a Tipperary man, one O'Driscoll, who was first employed by Sir Thomas Lawrence, then by doctors for whom he prepared anatomical drawings, and then by a gullible public whom he doctored himself. The young lady on whom Ingoldsbys wrote the epitaph died from the exhaustion of a frightful wound in her back produced by the embrocation:

Hic jacet in terra  
Pulchra puella:  
Volvit esse melior  
Dum fuit wella.

Qua causa mortis  
Infelix virgo?  
Aqua fortis  
Urens a tergo!  
Medicus? Nequaquam.  
Sed pictor signorum,  
In Tipperaria  
Inops bonorum.

Nunc dives auri  
Sedet sublimis  
In curru, celebratus  
Prosa atque rhyms!

Ah! virgo infelix!  
Hic intus jace  
In longum a Longo  
Requiescat in pace!

"T.P." could not resist adding an English epitaph on St. John himself with as happy a pun upon his name as "in longum a Longo":

Behold, ye quacks! the vengeance strong  
On deeds like yours impinging;  
For here below lies *St. John Long*,  
Who now must be *long singing*.

C. H. SEES (Brighton).—We do not really recall the name of one really famous scientific man in the New World or the Old who does not accept Darwin's theory as to the evolution of man from lower forms of life. There were a few distinguished scientists in opposition some years ago, but death has removed them from the scene.

### THE INEBRIATES ACT.

A SUBSCRIBER.—Dipsomania is not regarded in law as a form of insanity, so that it is difficult to apply compulsion. Under the recent Act means are provided for dealing with confirmed inebriates, but they still fall short of requirements. It is not even regarded as a sufficient reason for judicial separation.

A FOURTH YEAR'S MAN.—(1) Aillingham's "Operative Surgery" would answer your requirements admirably, and you might supplement this with "The After Treatment of Operations" by J. Lockhart Mummery. (2) Phillip's "Materia Medica and Therapeutics." (3) May, Swansy or Lawson, on "Diseases of the Eye."

A STUDENT OF SOCIOLOGY.—Your letter will appear in our next issue.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 20th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.)—4 p.m. Mr. J. Smith: Clinique. (Surgical.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.)—4 p.m. Mr. Hutchinson: Clinique. (Surgical.)

THURSDAY, JULY 21st.

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.)—5 p.m. Dr. H. Scharlieb: The Administration of Anaesthetics in Affections in the Respiratory System.

## Vacancies.

Ayr District Asylum.—Assistant Medical Officer.—Salary £120 per annum, with board, furnished apartments, attendance, and washing. Applications immediately to the Medical Superintendent.

Berkshire Asylum, Wallingford.—Second Assistant Medical Officer. Salary £140 per annum, with board, furnished apartments, attendance, &c. Applications to Medical Superintendent.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary £150 per annum, with apartments (not board). Applications to the Honorary Secretary, Mr. G. A. Lightfoot, 23 Lowther Street, Carlisle.

Combined Sanitary District of West Sussex.—Medical Officer of Health. Salary £650 per annum to include all travelling expenses. Applications to A. C. Coole, Solicitor 9 Carfax, Hoveham.

Dorset County Hospital, Dorchester.—House Surgeon.—Salary £100 per annum. Applications to W. E. Groves, Valetta, Icenway, Dorchester.

Stirling District Asylum, Larbert, N.B.—Assistant Medical Officer. Salary £150 per annum, with board, &c. Applications to the Medical Superintendent.

Township of Toxteth Park.—Resident Medical Officer. Salary £100 per annum, with board, washing, and apartments. Applications to J. Moulding, Clerk to the Guardians, 15 High Park Street, Liverpool.

Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to Edmund Forster, House Governor and Secretary.

## Appointments.

BARTLETT, R. C., M.B.E.C.S., L.E.C.P.Lond., Certifying Furgreen under the Factory Act for the Romsey District of the County of Hants.

BUSHNELL, F. G., M.D.Lond., D.P.H.Cantab., Pathologist to the Sussex County Hospital.

JOINTON, HENRY M., B.A., M.B., Chief Demonstrator of Anatomy in Trinity College, Dublin.

TAYLOR, GERRARD C., M.D.Cantab., D.P.H., Medical Officer of Health of the Urban District of Finchley.

WALKER, H. J., M.B., M.S. Edin., Certifying Surgeon under the Factory Act for the Brighton District of the County of Sussex.

## Births.

BUZZARD.—On July 15th, at 74 Grosvenor Street, W., the wife of E. Farquhar Buzzard, M.D., of a daughter.

CROCKER.—On July 13th, at Gort House, Petersham, Surrey, the wife of J. Hedley Crocker, M.D., of a daughter.

DIXON.—On July 12th, at Lynwood, Haven Green, Ealing, the wife E. Halstead Dixon, M.B.Lond., of twin daughters.

## Marriages.

LEGGATT-ANDERSON.—On July 14th, at St. Mary Abb'tt's, Kensington, Allen Worth Leggatt, son of the late H. Bethune Leggatt, to Lucy Hosack, second daughter of Izzet Anderson, M.D.Edin., of 23 Arundel Gardens, W.

OLIVER-BIGGS.—On July 12th, at All Saints' Church, Peckham, S.E. J. Latham, elder son of John B. Oliver, M.D., of 59 Parkfield Road, Liverpool, to Nellie third daughter of C. H. W. Biggs, Esq., of Glebe Lodge, Champaign Hill, London, S.E.

## Deaths.

KENNY.—On July 10th, at West Coker, near Yeovil, Jane Kenny, widow of the late John Kenny, Esq., of Dublin, surgeon, aged 87.

MARSHALL.—On July 13th, at Church House, Mitcham, Edward Marshall, M.R.O.S.E., L.S.A., aged 78.

## OPERATIONS.—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopaedic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street (9.30 a.m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynaecological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopaedic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (10 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynaecological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopaedic (2 p.m.), City Orthopaedic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (8 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

# The Medical Press and Circular.

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## Original Communications.

### COLOTOMY & COLECTOMY. (a)

By FRANK T. PAUL, F.R.C.S.,  
Surgeon, Royal Infirmary, Liverpool.

THE operation of colotomy has always attracted much interest. In my earlier days, when laparotomies were regarded with a serious suspicion, colotomy was the most popular of abdominal operations, and ranked in the appreciation of surgeons with lithotomy or the ligation of large arteries. From 1878 to 1889, when opportunity offered, I did, as other surgeons did, the classical lumbar operation; but when H. A. Reeves, Harrison Cripps and Herbert Allingham roused our attention in this country to the advantages of anterior colotomy, I followed their lead, and soon became convinced that it was correct.

There is no need now to revive the discussion as to which is the better operation. The first place was soon conceded to anterior colotomy, and year by year its success has become more firmly established.

Some ten years ago the value of colotomy in cases of rectal cancer was discussed at this Society. At that time several of the most experienced members of our Medical Institution were only prepared to advocate it as a means of giving relief when the most urgent and distressing symptoms were present. I remember it was classed with gastrostomy and gastro-enterostomy for malignant stricture as dangerous to life, and producing other ills almost if not altogether as unpleasant as those it was designed to relieve.

We may truly say now that we have changed all this, not only for colotomy, but for gastrostomy and gastro-enterostomy as well, but especially as regards colotomy. And one feels now that it is right to recommend the latter in any case of rectal cancer unsuitable for excision in which distressing symptoms are present or are indicated. Indeed, enthusiasts (and I may include myself) for high operations in extensive rectal cancer seem to be inclining again to substitute a permanent iliac colotomy for these very serious and wide operations; or to do it as a preliminary, and so lessen the risk of the subsequent proceeding.

Modern colotomy has unquestionably gained in favour, and this gain is due to two causes:—

1. Lower mortality.
2. Improved artificial anus.

The latter has, I consider, been the more important factor, for when a patient is labouring under a mortal disease it is more a question of comfort and the capacity to continue one's daily avocation than the simple prolongation of a more or less miserable existence. In the discussion to which I have referred, it seemed to be strongly felt that the discomforts of the artificial anus were frequently as great as those of the malignant ulceration. The want of control over the evacuations, the dependence upon assistance after each movement of the bowels, and the rather frequent occurrence of prolapse certainly rendered the life of a colotomy patient a far from happy existence. Now usually

very fair control is established in most cases, and prolapse hardly ever occurs; whilst with an anterior opening the patient can attend to himself a condition of independence which is greatly appreciated by the good, hopeful, deserving class of patients. I have no sympathy with those who give in. It is the duty of all of us not only to live but to work as long as we are able; and it is, as we all know, quite possible for any colotomy patient, not otherwise disabled, to do his daily work, whether active or sedentary, when the artificial anus is a good one.

Among the various suggested methods for doing iliac colotomy it must be conceded that, at any rate in England, Mr. Harrison Cripps' is that which has met with most general favour. Indeed, Mr. Allingham, who advocated a rival method, has of late accepted the former, except in cases in which the sigmoid mesentery is long, and the patient may be expected to survive a considerable time. In my judgment, Mr. Allingham's present position is a wise one. The variability of the anatomical conditions of the sigmoid flexure is such as to render it impossible that the same method of dealing with it can be the best for every case. And it certainly seems the fact that when the flexure is voluminous and its mesentery long, Cripps' method, however carefully accomplished, is very likely to be followed by a moist, patulous anus, over which it is difficult to create any control, and through which prolapse of bowel is very probable. Allingham's procedure is undoubtedly rather more severe; but it results in an excellent orifice, and the increased comfort when the operation is properly indicated is well worth the increased risk.

One desires from a colotomy—

1. Relief.
2. Safety.
3. Comfort.

First, as to relief. In cases of obstruction immediate relief is urgent. This perhaps applies to 20 per cent. of the cases; less when the disease is in the rectum, but more when it is in the colon. When the operation is undertaken with the necessity of giving immediate relief, I urge the glass-tube method, and I may do this with more confidence now than in 1891, when I first introduced it; for not only has my personal experience of the method been fairly considerable since that time, but I gather that it is now generally practised under these circumstances. Cripps' and Allingham's operations do not provide for the immediate opening of the bowel, but I have practised both operations many times and under all sorts of circumstances in conjunction with the glass tube, and have no reason to think that these operations are rendered appreciably more dangerous thereby. If this experience is correct, and it is true—as I believe it to be—that opening the bowel at the time of the primary operation does not appreciably increase the risk of life, then it is certainly a desirable addition in most cases; for not only is it convenient that the bowel should be open and free for the passage of flatus and fæces, but the wound in the abdominal wall may be smaller, a point of some importance, and the operation is completed at one sitting. There is no occasion for the subsequent incision and later paring of the mucous membrane required in Cripps' operation,

(a) Read at the Liverpool Medical Institution, Feb. 12th, 1903.



and no subsequent clamping and removal of bowel as in Allingham's. I therefore distinctly recommend that in doing either of these operations the glass tube should be used and the bowel opened at once, whether obstruction is present or not.

Next as regards safety. When the patient is in an exhausted condition, Cripps' operation, with or without the tube, should be selected, as the removal of bowel, especially if the mesentery be thick, increases the risk. Should obstruction be present, in introducing the tube every precaution must be taken to avoid leakage. In all cases both the bowel and the tube should be attached to the abdominal wall, the bowel by passing at least two green-gut sutures between it and the deep muscular aponeurosis, and the tube by passing its silk ligatures through the skin and knotting them. Then, if the tube is accidentally dragged on, it is well and safely anchored, and when it comes away, if the adhesions between the bowel and the parietal peritoneum are weak, they are backed up by the green-gut sutures.

As regards comfort, the essentials are—(1) A high operation, a small wound, and opening the highest portion of colon available, as recommended by Harrison Cripps. (2) The formation of a good spur. (3) Embodying the principle of Allingham's operation, whenever the sigmoid flexure is voluminous and its mesentery long, and the patient sufficiently robust to make this wise. (4) The use of a good plug, and the cultivation of a regular habit of bowels. After various trials with trusses and belts, I have come to use an aluminium mushroom plug made for me by Mr. Reynolds, of Liverpool. The plug or stalk is slightly bulbous, and long enough to pass through the whole depth of the abdominal wall. The head or flange is oval-shaped and wide; it is slightly concavo-convex, to fit the abdominal surface. A single layer of soft lint, with a hole in the middle for the stalk, is placed under the flange, and a good pad of cotton-wool above it, the whole being kept



ALUMINIUM COLOTOMY PLUG.

in place by a narrow abdominal belt such as I use after appendicectomy. This is the cleanest and far the most comfortable and effective apparatus I have yet tried.

In 1898 I designed an operation to give better control over the artificial anus. It involved using Madelung's method of closing and returning the rectal end of the bowel into the abdominal cavity, while the upper end was brought out at a distance after having passed between the muscles—in fact, after the principle of Hahn's or Frank's gastrostomy. The operation was effective but dangerous. It was unnecessarily severe, and in passing the bowel between the muscles septic infection was liable to occur. For these reasons I soon abandoned it, and I think now that sufficiently good control can be obtained by ordinary methods.

The details of a colotomy by the glass-tube method are as follows:—

1. The incision is made in accordance with accepted principles, but may be smaller, that is,  $1\frac{1}{2}$  to 2 inches, according to the condition of the abdominal wall and the bowel.

2. If the mesentery be very short, the bowel is firmly drawn out and a running suture of medium thick silk inserted round an oval area involving as much of the circumference of the bowel as possible, so as to ensure its posterior wall being well brought up to the surface to form a good spur. The enclosed area is then gripped with two catch forceps, incised, the tube plugged with wool inserted, and the ligature tied. A second silk ligature is then simply tied over the first to render it more secure, and is knotted on the opposite side of the

tube. Two or more green-gut sutures are next passed between the outer coats of the bowel and the deep tissues of the wound, and finally the ends of the silk ligatures are passed through the skin and tied so as to secure the tube in case of roughness or accident. Usually the wound is too small to need any further sutures. The parts being septic are well powdered with iodoform, and dressed with cyanide gauze and wool as usual, and a binder split to transmit the tube is firmly applied. If the bowel be empty, a light plug of wool is kept in the tube. If loaded with formed motion a sponge bag containing some iodoform wool or wool sprinkled with eucalyptus oil is attached. If with loose motion a short piece of Down Brothers' thin wide indiarubber tubing is attached to the glass tube and allowed to fall into a basin at the patient's side.

3. If the mesentery be long and the patient in good condition, the loose loop of sigmoid flexure should be drawn out, the mesentery ligatured separately, a large tube fastened into the top end and a small one into the bottom end, and then all the redundant bowel cut away. It is better not to ligature the mesentery together with the bowel to the tubes, as, unless the grip is very tight, some of the vessels are liable to draw out, and smart hæmorrhage may result. It will be found much safer to tie the mesentery in two or three sections by itself. When the sigmoid mesentery is of medium length either method may be used, but in all cases when doing Cripps' operation, care must be taken to insert the tube into the highest portion of bowel which can be brought out of the wound, and to include the whole or almost the whole circumference of the bowel.

Usually on the fifth day the tube is ready to come away. When this is the case, indicated by leakage beside the tube, the silk sutures are cut and it is withdrawn.

4. Subsequently, the patient is kept in bed, the motions being passed into the dressings until the wound is healed, when the plug and belt are worn.

*Colotomy in other regions.*—For some time I maintained it was our duty to do colotomy as low down in the bowel as we could, consistently with being well clear of the disease. Now I am inclined to think that there are only two good colotomies, sigmoid and transverse. In the few cases in which I have had to do the latter it has answered very fairly well. Not so well as sigmoid, but decidedly better, I consider, than the lumbar operation. Right iliac colotomy I do not like at all; the motions are liquid, and quite uncontrollable. I never do it except in cases of obstruction, and then only in the hope and expectation that subsequent enterectomy or short-circuiting will be possible. When the cæcum is opened only a small tube should be used, one of  $\frac{1}{2}$  to  $\frac{3}{4}$  inch diameter being sufficient.

It has been said that subsequent trouble will result if either the sigmoid or the cæcum is opened and attached in the middle line. I have had to do this occasionally, and in practice no inconvenience has resulted. One would never choose this position, but at any time there may be urgent reasons why one should accept it.

The operation of colotomy is so closely associated with that of colectomy that I can hardly treat of one without reference to the other. Often when colotomy only is intended before exploration, colectomy is ultimately undertaken, or the reverse may be the case; while, as I have stated, it is no unusual thing for me to cut away several inches of colon, with the simple object of improving the character of an artificial anus. When, however, the original intention is colectomy, there are a few additional points which need careful consideration. The chief of these are, the exact location of the disease and the restoration of the continuity of the bowel.

It is a great misfortune that malignant disease of the colon is so very undemonstrative in its early stages. Recently, in one week, I was asked to see three cases, all too late for operation; that is, in all the tumour was hopelessly adherent to neighbouring important structures. This form of cancer is one of the least malignant with which I am acquainted; and could one obtain the cases early enough, as happens more



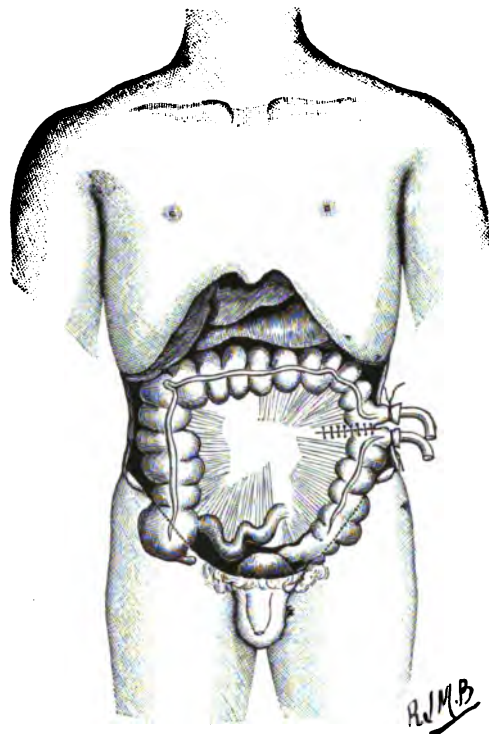
frequently in the rectum, the results would be excellent. In its first stage, however, it apparently sets up no recognisable symptoms, and I have no doubt it often exists for several months, or a year or two, according to the type of growth, before any evidence whatever of its presence is afforded. The earliest symptoms are frequently those of intestinal indigestion, brought about by some difficulty in the contents of the bowel passing the diseased part. They are flatulence, slight colicky pains, some distension, and irregularity of the bowels. In other cases there are no obstructive symptoms at first, but mucus and perhaps blood appear in the motions. At a later stage some obstruction is usually present, characterised by increasing constipation, with attacks of colicky pain. Loss of flesh occurs, and ultimately a tumour is discovered in some cases, while in others the surgeon is called in because complete obstruction has supervened. The clinical details are influenced by the character of the growth. From 35 to 45 or 50 the disease is generally of the fungating type, and produces more of a tumour than an ulcer. In these cases there is often no obstruction, but plenty of mucus and blood in the motions. The abdomen is not distended, and if carefully palpated the tumour might usually be discovered much earlier than it is. Still one must bear in mind that the patient suffers little, and frequently makes no complaint until it is too late. Indeed, it is sometimes the discovery of the tumour by the patient himself that leads him to consult his doctor. From 50 to 70 or 80 the growth is usually of the chronic ulcerating type, producing the ring stricture. In these cases the symptoms are almost entirely due to obstruction, which in the end generally becomes complete, owing to the narrow lumen at the strictured part (often only transmitting a No. 10 catheter) becoming blocked by some coarse undigested substance in the *faeces*.

When distension is absent a tumour is often present, and in this way the disease is usually located in the younger class of patients; but after obstruction has once set in, it is rare to be able to detect a lump, and one must be guided in other ways in locating it. Probabilities are of no help. One must never cut down over a particular region because that is statistically the most probable site of the disease. In the absence of stronger evidence exploration in the middle line should be the practice. The best aids to diagnosis are the capacity of the bowel below the stricture, the condition of the *cæcum* and colon as made out by percussion and palpation, and the evidence afforded by pain and peristalsis. The patient is often quite conscious of the site of the stricture, having many a time felt a colicky wave of peristalsis pass away at a particular spot with a gurgling sound, as gas and liquid were forced through the stricture. And when the bowel is much hypertrophied, one may see the peristaltic wave gather and run on until it comes to a stop at the stricture. The enema, too, is a great help when the disease is low down. As the result of experiment on the dead subject, I believe the bowel will hold something like two pints with an obstruction in the sigmoid flexure; but in actual practice one finds that half a pint to a pint is all that is tolerated, usually the former, and that it is returned at once without motion. Under these circumstances the tumour is in the most favourable place for operation. When it is higher up large quantities of injection may be introduced and retained. One has then to be guided chiefly by palpation and percussion of the regions of the large bowel, and if nothing definite can be made out a middle-line exploration should be undertaken.

When the tumour is located it must be freely exposed, and if suitable for removal the mesentery in connection with the part involved is carefully divided, so that the diseased coil of bowel may be brought out of the abdomen. The subsequent steps of the operation depend upon the mode of union to be attempted, and in regard to this I continue to differ strongly from those who consider primary end-to-end union by suture or button the proper course to adopt as a routine practice. That it is the neatest and most satisfactory to the surgeon when the patient lives I do not doubt; but it

is certainly more dangerous, without ultimately being at all more efficacious than when the ends of the bowel are brought out, and the continuity of the canal subsequently restored. When this is done it is a rare thing to lose a patient who is not at the time of the operation seriously depressed as the effect of several days' obstruction of the bowels. In this connection I may, as a surgeon, warn my medical friends that a patient after ten days' obstruction in the lower bowel is in much worse case than his pulse and appearance seem to indicate. One is asked to do colotomy under these circumstances with the assurance that the patient is in excellent condition. It is true that he is quite fit to bear the operation, but when he dies a few days later, death should be ascribed to the absorption of toxins, which is the cause of it, and not to the operation, which has had nothing to do with the unfortunate result.

I commenced operating by bringing out the ends of the bowel in 1892, and after ten years' experience am strongly confirmed in my opinion that it is the right thing to do. I know nothing against it, except that the patient has the discomforts of an artificial anus for a few weeks, and the course of the case is prolonged by about a month—small evils compared with the gravity of the disease and the risks of end-to-end union. It has been suggested that stricture might result from

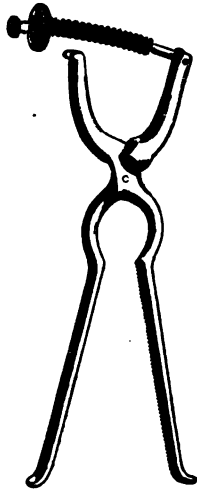


incomplete removal of the spur, but such has not proved to happen in any of my cases.

After dividing the mesentery the subsequent steps of the operation are of the simplest. The tumour being well drawn out of the abdomen, the ascending and descending portions of the colon are made to lie side by side, like the barrels of a double-barrelled gun, in which relationship they are lightly sutured together for quite three inches inside the abdomen. Outside the abdomen a colotomy tube is ligatured into the upper end and a smaller tube into the lower end, when the diseased part is cut away, of course quite bloodlessly. A few fine sutures may be used to attach the bowel to the parietal peritoneum at the bottom of the wound, and if the incision has been long, its ends are brought together with fishing-gut sutures.

In many cases the operation is very little more severe than colotomy. Five or six days later the tubes separate, and at the end of three weeks, as a rule, the

carefully prepared spur may be clamped. I once had a warning that this should not be done too hastily.



CLAMP FOR REMOVING SPUR AFTER ENTERECTOMY.

After complete obstruction the bowel is liable to be in a very septic and irritable condition, and so long as the spur feels thick and hard to the finger I believe it to be unwise to apply the clamp. As a rule it is supple throughout, and under these circumstances may be clamped at any time. One clamping is very likely to be insufficient, and if there is a considerable ridge still apparent at the bottom the clamp should be applied again. It need not be kept on each time until it comes away, as its work is thoroughly effected in forty-eight hours, when it is probably safer removed than left *in situ*. Messrs. Down Brothers have recently made me a new clamp, which has proved very useful. The compression is maintained by a steel spring on a projecting arm, which can be disengaged to facilitate introduction. As soon as the spur is completely destroyed the artificial anus is closed. The entire operation has been completed in twenty-four hours, but usually six to eight weeks must be allowed for it. In cases of malignant disease of the colon in which the mesenteric glands are involved I used to give a most depressing prognosis, but have now met with a few in which such a prognosis was not justified. About five years ago I removed a cancerous tumour of the sigmoid, together with several enlarged glands in the attached portion of the mesentery. The glands were as large as filberts, and I thought the case quite hopeless; nevertheless she is still in excellent health, and continuing her vocation as a domestic nurse.

Nearly three years ago I removed the cæcum and lower part of the ileum from a gentleman, æt. 37, for a soft malignant growth. The lump was the size of a fist, and several glands were enlarged, one measuring an inch and a half in diameter. Here, again, I gave a bad prognosis. He recovered well from the operation, and a year later was in such excellent health that his medical friend, Dr. Heatherley, refused to countenance any longer a pessimistic outlook. He came to me and said, in effect—"Look here, you must do something for this fellow. He must not be condemned to die in this sort of way. How about X-rays?" Well, I do not think we have at present any information which warrants us to suppose that X-rays would influence the course of such a case, so I suggested that if the patient was willing to lay up for a month I would explore the abdomen, ascertain what the present condition was, and do what seemed to be best in his interests. This was decided on; and one day, after quite half an hour's exploration, I succeeded in discovering and extracting one small gland the size of a split pea, which on microscopical examination showed no malignant change. Another year and a half passed and the patient is still as well as ever—so well, in fact, that he at once agreed to come here with Dr. Heatherley to show us that we

know almost as little about the prognosis as about the treatment of cancer. (a)

## ON THE NECESSITY FOR SCHOOL HYGIENE. (b)

By J. C. McWALTER, M.A., M.D., D.P.H. Dub.

THE sense of parental responsibility has been greatly lessened by the operations of a Compulsory Education Act, and now the public look to educational authorities for that training of the child, both mental and physical, which may fit it to be a good citizen. The need for some knowledge of reading and writing is surely not more pressing than the necessity for the development of a vigorous and healthy frame, for sound teeth, for well-developed muscles, for keen eyes, for steady nerves. As all these can be obtained or improved by intelligent training, an obligation rests with the local authorities to supply not only competent instruction in literary or technical subjects, but skilled advice available for the proper physical development and examination of the pupils.

Not only does compulsory education demand the possession of the child for half the day, but it monopolises it for all the period during which the parent might otherwise obtain expert advice regarding its teeth, its eyes, its nose, its throat, its chest, its spine, &c., and thus the parents can scarcely be blamed if they neglect these matters and allow the children to grow up comparatively deteriorated specimens of humanity.

The comparative ease and cheapness with which the examinations of a medical attendant can be effected in a school should be a sound economic argument for their more universal adoption. It is possible to get the services of an ophthalmic surgeon of considerable skill to overhaul the eyesight of every scholar in a school of a couple of hundred in a comparatively short time, and for a moderate fee, although the services of such a specialist would normally be outside the powers of the family of any one of the scholars. Skilled rhinologists are available to detect the various abnormalities of the naso-pharynx, and so save a lifetime's discomfort to many a child. The numerous osseous abnormalities which deform so many of our young scholars are notoriously easy of rectification or prevention where the skill of an orthopædic surgeon or of a scientific instructor of gymnastics is utilised.

A cry has gone forth from almost every doctor in the kingdom calling on the Government to provide for the regular scientific teaching of young scholars in the principles of temperance and hygiene, and thus the foundation of healthier and happier homes must be laid. The Socratic principle, that vice is due to ignorance, and not to innate depravity, is becoming recognised as the proper guiding rule for the State when it takes on itself the training of children, and this principle is perhaps even more potent when dealing with physiological than with psychological sins. Habits of hygiene, acquired in the school days, are obviously of much more influence than spasmodic efforts to attain sanatorial righteousness when attempted in later life.

The researches of Dr. Kerr seem to incontrovertibly prove that a grave deterioration occurs in the health of children whilst at school, for which the system of education is responsible. Thus he found that whilst about 10 per cent. of school children had various defects of vision, only about 3 per cent. were abnormal on entry. It was proved that the vision of 7 per cent. of school children had become affected by some circumstances of their training—circumstances which should be avoidable and preventable under an enlightened scheme of examination by competent medical officers.

(a) Dr. Heatherley tells me that this summer he made fifty runs in a cricket match—not a bad performance for a man without a cæcum.

(b) A Paper read at the Folkestone Congress of the Royal Institute of Public Health, July 21st, 1904.

It is well known that scarlet fever, measles, whooping-cough, mumps, phthisis, and such ailments as ring-worm, ophthalmia, and itch ensue on the aggregation of children at the most susceptible ages in ill-lighted, ill-ventilated, and often dirty school-rooms. The deaths from measles occur almost entirely under the age of five years, and in nine cases out of ten epidemics may be traced to the infant departments of schools. Seventy per cent. of scarlet fever cases are stated to occur among children who would attend such schools. In some districts, 25 per cent. of the cases of diphtheria are between the ages of three and five, and nearly all the cases of whooping-cough occur in children attending school. Regarding phthisis, statistics are less exact, but there is little doubt that numerous deaths, classed as due to convulsions, typhoid fever, brain fever, and the like, are really cases of tuberculous meningitis, contracted in school-rooms, whilst the larger part of deaths classified as due to bronchitis, under the age of ten, are really examples of broncho-pneumonia of a tuberculous origin, and the *fons et origo mali* is a source of infection in the school-room.

In his Harben Lectures given this year, Dr. Hueppe asserts that the three factors which give rise to consumption are predisposition, stimulus, and condition. Now in our schools children come together from all kinds of homes—from the most depraved and filthy to the more highly respectable. Some of them are half starved, and some not physically fit to acquire any knowledge. Where such a crowd of children is huddled together, there is a slow undermining of health from the want of fresh air, which soon establishes a favourable condition for the development of phthisis; the predisposition is only too often in the family, and the immediate stimulus is fairly sure to be brought in unless the children are periodically inspected and the more delicate ones removed. When an inspection can be made at the beginning of every term, every child in the room should be examined by a medical officer, and those suffering not only from infectious disease, but from itch, ringworm, vermin, &c., those apparently unfit to receive instruction through delicacy, or those in any doubtful condition, could then be sent home and not readmitted until they produced a certificate from their own doctor that they were fit to resume. The problem of excluding phthisical children is a grave one, but is best dealt with by a *periodical weighing* of all the children, which can easily be done by an intelligent teacher under the direction of the medical officer. If a periodical progression, according to a given scale, be not observed, the child must be subjected to further examination.

Then open-air instruction ought to be availed of far more freely than at present. Nothing is more notorious than that phthisis and other communicable diseases prevail to an enormous extent in many parts of the country where all the natural advantages make for the most perfect health; but the healthiness of dwellings and schools is often in the inverse ratio to the salubrity of a locality. The worst examples of sanitation in schools and rooms is found in the best parts of the country. I am constantly shocked by the number of cases of phthisis which I find in a seaside village which ought to be a health resort; even a few home industries there appear to be mere foci for infection. The morbid horror which certain country people exhibit for air or light in their bedrooms, and their contemptuous disregard for sanitation, are of course the cause. If the teacher of the village school was compelled to conduct his operations in the open air, where practicable, his health and that of his charges would alike benefit.

A valuable means of detecting the incipient signs of ill-health is obviously the weighing-machine. No teacher can be expected to exhibit such proficiency as to enable him to detect diphtheria or adenoids or astigmatism, but every school superintendent is competent to take the weight of his pupils periodically, and to see if they answer to a certain scale. It is, of course, well ascertained that no surer sign of disease exists than insufficient increase in the weight of a

growing child, and there is always a proportionate increase when every function is normal. Children who fall below their average can easily be brought under the notice of the medical attendant and subjected to a more thorough examination.

Again, the age at which the child must be sent to school ought to be not five but six years, and no infant under five should be accepted. It is thoroughly proved that children who start schooling at six or seven years rapidly overtake those who commenced at four or five, and to admit infants of such a tender age is merely a concession to the laziness of the parents who seek to get rid of them for five hours a day.

Dr. Martin, of Gloucester, sagely suggests that cases where it is sought to exclude children from school because of their generally dirty or verminous condition should be treated by graduated pressure. First he suggests that an informal notice should be sent the parents, apprising them of the facts, and if this did not avail a formal intimation that the child would be excluded until the trouble was remedied.

When one speaks of a systematic examination of a school the question of cost at once jumps into prominence. Dr. Martin proposes to give the medical officer a guinea for a complete examination of a school of from 50 to 100 pupils, and two guineas where the number goes up to 300. As such a complete examination need not take place oftener than once a term, its cost is not prohibitive. In his district the average attendance is 87.5 per cent., and he calculates that a gain of 2 per cent. resulted from the periodical medical examination of the scholars, which meant in that county £1,600 a year.

Habits of cleanliness are of far more educational value to the children who attend our elementary schools than most of what they are taught to learn. It should, therefore, be strenuously insisted on that every school be provided with an adequate lavatory. To have, as is so often the case, a couple of towels for a hundred pupils is, of course, to propagate disease and uncleanly ideas.

The Royal Commission on Physical Training has already recommended that provision should be made for the regular medical examination of school children; but a practical and complete scheme for inspection is still wanting, and it should be the function of a body so representative of every school and class of sanitarians as the Royal Institute of Public Health to supply it. Many authorities consider that a child should be thoroughly overhauled at least three times during its school life, but, on the other hand, the cost of such a scheme would be very high, as it is calculated that the whole time of a medical officer of health would be taken up examining the school children of a town of 100,000 (say with 16,000 school children). But obviously, a Congress such as this will lead to the better informing of public opinion, when the cost will no longer be regarded as unprofitable.

## LARGE FIBRO-CYSTIC TUMOUR OF THE UTERUS

(WEIGHT 28½ LBS.).

REMOVED BY ABDOMINAL HYSTERECTOMY; FOLLOWED BY GANGRENE OF THE RIGHT LEG. (a)

By FRED. BOWREMAN JESSETT, F.R.C.S.,  
Surgeon to the Cancer Hospital, Brompton, &c.

E. G., æt. 54, married 33 years, five children, youngest æt. 22; has not, so far as she can perceive, reached menopause.

Six years ago an exploratory operation was performed at a London hospital for "flooding and tumour." According to the report from the surgical registrar, "a large uterine fibroid was found. Nothing further was done." Soon after leaving the hospital she had two floodings, more since. Now, the abdomen gets very big, no pain, but patient is unable to get about properly.

(a) Paper read at the British Gynaecological Society, July 14th 1904.

Varicose veins in legs for last three years, and occasional ulcers. General health fair, but is losing flesh. Constipated; menstruation regular every four weeks, lasting about a week; loss slight.

*On Admission.*—Florid, but thin. Abdomen enormously distended, umbilicus flattened, old median scar below it. Large mass occupying practically whole abdomen, dull on percussion, no thrill, not tender. Superficial veins distended.

*Per Vaginem.*—Uterus low down and cervix directed to right. Mass felt through posterior fornix.

She was admitted into the Cancer Hospital on Wednesday, June 1st, and on the 7th Mr. Jessett operated: An opening about three inches in length was made in the middle line below the umbilicus for exploration. The tumour was found to be firmly adherent to the parietes, but by using some considerable force the parietes could be peeled off. The whole scar tissue was removed by an elliptical incision, and the abdominal incision enlarged to enable the hand to pass round the tumour, when it was found to be quite free behind and the intestines well pushed up and not adherent. Mr. Jessett then, by bringing his hand up from behind, was enabled to peel the parietes quite free from the tumour, which was then readily shelled out, not, however, until the parietal incision had been prolonged from the pubes quite to the ensiform cartilage. The omentum was adherent to the tumour and had some very large veins. This was ligatured in segments and cut across. The broad ligaments were then tied and divided; the uterine arteries secured, and the cervix uteri cut across, after having stripped down an anterior and posterior flap of peritoneum. There was a considerable amount of oozing, so Mr. Jessett packed the cavity with iodoform gauze and brought the end out of the lower angle of the parietal wound.

The patient suffered a good deal from shock during the operation and after the removal of the tumour, which weighed 28½ lbs.; so Mr. Keyser injected four pints of saline fluid into the median basilic vein, and a subcutaneous injection of strychnine was also given. After stitching up the peritoneum, two pints of saline fluid were introduced into the peritoneal cavity before finally closing the parietal wound.

The patient was returned to bed and seemed as well as could be expected. She, however, complained of a good deal of pain in her right leg, which was somewhat dusky and cold. This was wrapped in cotton-wool and flannel bandages. Had a fairly good night, but showing signs of some collapse, two pints more saline fluid were given by the arm, and small quantities of saline fluid and brandy and beef-tea administered by the rectum.

*June 8th.*—Pulse small, but good; temperature normal. No distension; gauze drainage removed. No sickness or vomiting. Ordered brandy, milk, and lime water by the mouth, which she retained. General aspect fairly good. Leg still somewhat discoloured but warm. Not so painful. Rectal feeding continued.

The patient gradually improved from day to day, the abdomen keeping quite flaccid. Bowels opened, kidneys acting well, and she takes plenty of nourishment.

*June 13th.*—Patient expresses herself better and stronger, takes all nourishment. The leg, however, is quite gangrenous from the knee downwards, being discoloured and cold, due undoubtedly to impeded blood supply, the skin being dry and shrivelled. No sensation below the knee. There are a few blebs. The limb is kept wrapped in boric lint, dusted with boric acid powder and the whole enclosed in a quantity of cotton wool.

The line of demarcation is just above the patella, tending downwards and backwards to about two inches below the joint posteriorly. The patient continued to improve daily, and on June 21st, fourteen days after the operation, with the assistance of Mr. Churchill, I amputated the leg at the junction of the upper and middle third of the thigh. She bore the operation remarkably well, and suffered very little from shock.

Before the operation she had a nutritive enema of brandy ʒj, beef-tea ʒij, administered.

*June 22nd.*—Has passed a good night and taken a small amount of nourishment. She has also been sustained by nutritive enemata. Ordered beef-tea, egg and brandy, milk and champagne.

*June 23rd.*—Stump dressed, a good deal of oozing from the drainage-tubes; stump looks well. Patient's condition generally satisfactory. Pulse good quality, but very quick. Temperature normal.

Patient gradually lost ground and died on Sunday, the 25th, four days after the amputation, and nearly three weeks after the removal of the tumour.

*Post-Mortem.*—The abdominal wound was quite healed and firm. There was some suppuration in the stump. The external iliac was found to have a firm clot in it extending from its junction with the common iliac for about one inch downwards.

The kidneys were both much diseased and degenerated; this was not suspected, as the urine was tested before the first operation, and only showed very slight traces of albumin; possibly the pressure of the tumour may have had something to do with this.

This case is of interest on account of the size of the tumour and also in respect to the gangrene of the leg. That this was caused by the plugging of the external iliac there can be no doubt, but it is difficult to understand why this artery was plugged as there was no sign of its being involved in the ligature or twisted. Could it have been caused by the pressure of the tumour? But, even then, why was not collateral circulation established? It has been suggested that these clots may be the result of bacterial infection. In this case it could hardly have been so, as the patient complained of pain, and the leg was somewhat dusky within an hour of the completion of the operation.

## DETACHMENT OF THE CHOROID.

By ROBERT DWYER JOYCE, F.R.C.S., &c., &c.,  
Ophthalmic and Aural Surgeon to the Richmond Hospital, Dublin,  
and St. Michael's Hospital, Kingstown.

A LADY, æt. 59, consulted me recently for blindness of her right eye.

The patient is healthy, no cardiac or renal trouble; she suffers, however, frequently from constipation. There is no history of a blow or injury of any sort to the eye, nor was it ever inflamed more than the ordinary redness from a cold; but the patient fell—not very violently apparently—on the back of her head about eighteen months ago. Patient says quite distinctly that her right eye was always better than the left for distance as well as for near work (she used to shut the left when threading a needle, &c.), but one evening, about three months ago, she discovered that it (R.) was blind. She was greatly frightened. Her sister at once took her in hand, and poulticed the eye with bread and water continuously for a whole day and night; without avail, however, as she did not succeed in making a cure. Patient wears —1.25 sph. glasses, both eyes, for distant vision.

Present condition:—R. eye: vision = 0 (when full sunlight was reflected into the eye she said she "thought she saw something").

L. eye: vision =  $\frac{6}{20}$  >  $\frac{5}{20}$  with — 1.5 sph. C — 0.25 cyl. ax. hoz. R. eye is quite normal superficially, but the pupil, 4 mm. in medium light, was larger than the other. With the ophthalmoscope (direct method, i.e., without any intermediate lens) retinal vessels can be seen when viewed from a distance of about ten inches from the eye. With the indirect method, the whole fundus is seen to be occupied by two large bulging abrupt prominences, separated

from one another by a very deep furrow, nearly vertical, but slightly inclined towards the nasal side, above. From the position of this furrow the optic nerve head would be situated in it, but it was not visible. The two large prominences were almost the colour of the ordinary normal fundus, but were slightly more yellow, and gave, in places, the idea of translucency. They were covered by the retina, the vessels of which were perhaps a little darker than normal. Besides these, however, the close characteristic network of the choroidal vessels could be seen without difficulty over the upper and also over the inner part of the nasal prominence, and they were situated in the same plane as the retinal vessels. I was unable to see any trace of choroidal vessels elsewhere. No undulatory movements of the prominences were visible when the eye moved, like those seen in simple detachment of the retina.

The tension was down (-1). I could detect no disease of any visible part of the retina, but the walls of the retinal vessels were thickened. The anatomical condition in this case is evidently large detachment of the retina corresponding to the two prominences, with two small detachments of the choroid, situated at the places where the choroidal vessels were visible.

Detachment of the choroid, following extensive loss of vitreous, or injury, is not very uncommon, but pure idiopathic cases, like the above, are among the very rarest diseases of the eye.

### Transactions of Societies.

#### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, JULY 14TH, 1904.

DR. H. MACNAUGHTON-JONES, Vice-President, in the Chair.

MR. CHRISTOPHER MARTIN exhibited the following specimens—(1) Bone crochet hook removed from the abdominal cavity; (2) and (3) Two specimens of Arrested Development of the Uterus; and read the following notes:—

1. My first specimen is a foreign body which I removed from the abdominal cavity in December last. It is a portion of a bone crochet hook about five inches long. The patient was a widow, æt. 48. She had missed her periods for a few months, and believed she was pregnant. With the object of procuring abortion she got a bone crochet hook, and having sharpened it to a point, pushed it up into the uterus. It slipped from her fingers and she was afterwards unable to get hold of the end of it. It worked its way right through the uterus and became free in the peritoneal cavity. She became alarmed, and consulted her own medical man, who sent her to me, and when I examined her a fortnight after the occurrence, I could feel the foreign body lying in the left iliac fossa quite apart from the uterus. She was a very thin woman, so that it was quite easy to palpate it. She was not pregnant. I opened her abdomen and found this bony rod lying in the left iliac fossa, completely embedded in the omentum. It was easily removed, and she made a good recovery from the operation. On looking at the uterus I could see on the posterior aspect, just above the level of the internal os, a round, depressed scar—evidently the spot through which the rod had passed. There were a few adhesions between the omentum and the small intestine, but there were no signs of inflammation in or around the uterus itself. When I saw her she was in a very strange mental condition bordering on insanity. She was firmly convinced that she was pregnant and that she would still have to be confined, and would have to go to prison for attempting to procure abortion. I saw her again about two months ago, and then found

that she had developed cancer in the breast, which, however, she refused to have removed.

2. The next specimen illustrates one variety of arrested development of the uterus. The patient was a single girl, æt. 18, who had never menstruated. About the age of fifteen the usual external signs of puberty appeared, and she began to have monthly attacks of pain in the pelvis, lasting for a few days. These monthly pains gradually increased in severity until she saw me. When I examined her I found her a well-developed girl as regards figure and mammae. The vulva was normal, but there was no vagina except a small cul-de-sac about half an inch deep. On passing the sound into the bladder, and finger into the rectum, it was evident that nothing intervened except the vesical and rectal walls. I opened her abdomen and found that the uterus was represented by two small solid muscular bodies, one on each side of the pelvis. Each of these bodies received at the upper end a small Fallopian tube and a well-marked round ligament. Below, each body faded away in the cellular tissue between the bladder and the rectum. The right body was better developed than the left. The ovaries were well developed and apparently normal. There was no structural connection between the uterine body of one side with that of the other; they were, indeed, separated by a gap of two inches. As I was anxious to stop the monthly paroxysms of pain, I removed both the ovaries, together with the Fallopian tubes and the representatives of the uterus. The patient made a good recovery; she has since remained well and is quite relieved of her old pains. It is evident that in her case the two ducts of Müller did not coalesce, whilst the uterine and vaginal portions were arrested in their development and did not form mucous canals. A week or two ago the patient came again to see me, looking very well, and she informed me that she was thinking of getting married, and was anxious to know if I could make her a vagina.

3. The third case is one in which the uterus was bicornuous—the right horn being distended with menstrual fluid and not communicating with the rest of the uterine cavity. The patient was a single girl, æt. 21, anæmic and delicate, who consulted me on June 1st, 1904, complaining of violent pain in the right lower abdomen at each period, lasting the whole of the time and continuing some days afterwards. Menstruation occurred every three weeks, was scanty and only lasted three days. On examining her I found a mass about the size of an orange, in front of and to the right of the uterus—a mass which I took to be tubal or ovarian. I took her into the hospital and on June 18th I opened her abdomen. I found the mass to be the right horn of a bifid uterus. It was tense and globular, and evidently contained fluid. It was separated from the rest of the uterus by a bridge of fibrous and muscular tissue. The distended right horn, right tube and ovary were very adherent. I removed them by dividing this bridge and was able to save the rest of the uterus with the left ovary and tube. The patient made a good recovery and returned home on July 10th.

Dr. HEYWOOD SMITH said that it was remarkable how often sounds or other instruments passed through the uterine wall without setting up any mischief. One lady he knew had brought on her own miscarriage thirty-five times, and on several occasions nearly lost her life from severe flooding; she used a long knitting needle for the purpose. Malformation or displacement of the kidney was so often associated with arrested development of the uterus that he would like to know whether Mr. Martin had examined the position of the kidneys.

Mr. BOWREMAN JESSETT suggested that the last specimen might possibly be a fibroid or myoma of the Fallopian tube; it did not, in his opinion, resemble a bicornual uterus.

Dr. ROBERT BELL (Glasgow) mentioned a case he operated upon for a tumour which he took to be a subserous fibroid of the uterus or possibly, as its attachment was at the cornu, of the Fallopian tube, and he removed it under that impression. The woman had been pregnant two years previously, and the pregnancy



had terminated suddenly, a fact which he did not ascertain till after the operation. On a section being made of the tumour it was found to contain a four and a half months fetus in perfect preservation. The tumour weighed four pounds and had all the appearances of a fibroid.

Dr. H. MACNAUGHTON-JONES (Chairman) said that it was remarkable what a variety of instruments could be used to procure abortion; he had known the handle of a toothbrush successfully employed for the purpose. One of the unpleasant consequences which might follow such attempts was that imputations quite unfounded might be cast on the ordinary medical attendant. In a uterus examined by Mr. Bland-Sutton and himself there was a perforation, and a portion of cotton wool was found in the abdominal cavity. The woman had been attended by a midwife, but the consequence to her ordinary medical man was very disastrous. Mr. Martin's second case was of much interest; among five cases of total absence of the uterus and ovaries he (Dr. Macnaughton-Jones) had himself published, two were in children and in one of them he had succeeded in making a very fair artificial vagina; in the other, particulars of which he had read to the Society at a former meeting, the abdomen was opened for inflammation of the appendix, which was bound down to the floor of the pelvis. Before the operation he had been able by a vesico-rectal examination to determine the absence of the uterus and ovaries. He might refer to one of the three other adult cases as it had a bearing upon the question of making an artificial vagina, as von Ott and others were reported to have done successfully. In his own case he had not been able to make a good vagina and a rectal fistula was left. He was able to close the latter successfully, but had to sacrifice the substitute for the vagina he had made. Before the operation the mental condition of the patient was such as to cause grave anxiety; she had become hysterical and almost delusional, and was greatly reduced in strength; after the plastic operation her health improved greatly and she became, and has remained, robust and well. It therefore seemed that the production of even a small artificial vagina might have a good effect. He was not sure that Mr. Martin's third specimen was a uterus, and suggested that it should be examined by a pathologist.

Mr. MARTIN, in reply, said that there was nothing to lead him to suppose anything anomalous about the kidneys, and examination of their position would have involved a larger incision than he cared to make. A section had now been made of the third specimen and the centre evidently consisted of inspissated blood-clot, which, he held, supported his view that it was the occluded horn of a bicorned uterus filled with retained menstrual blood. The specimen had been hardened by formalin, but when removed the tumour was quite flaccid. Dr. Macnaughton-Jones had referred to the medico-legal aspect of the first case. If it had proved fatal, it might have been his duty to decline to certify. It was remarkable how little trouble the very sharp piece of bone had caused; perhaps it had been cleansed of any infectious germs in its passage through the muscular wall of the uterus, but the mental state of the woman might partially account for her immunity. Insane women were curiously tolerant of abdominal injuries, and in many instances had opened their own abdomens and yet recovered without any bad symptoms from conditions that, in all probability, would have led to fatal peritonitis in others. He was convinced that the third specimen was an occluded horn with retained menstrual blood, but he would be pleased to have it examined by a pathologist, as suggested, and would submit a report to the Society.

Mr. BOWREMAN JESSETT reported upon a case of  
GANGRENE OF THE LEG AFTER ABDOMINAL  
HYSTERECTOMY

for the removal of a large fibro-cystic tumour, and showed the tumour removed. Notes of this case will be found on page 85.

Mr. JESSETT also showed a  
MYOMATOUS UTERUS, REMOVED BY ABDOMINAL  
HYSTERECTOMY,

illustrating the presence of sub-mucous, interstitial and sub-peritoneal growths, and read the following note:—

A. H., æt. 50, married, no children or miscarriages, was seen by me in consultation with Dr. Smyth, Colebrook Road, on June 2nd, 1904. *History:* For about two years has had aching pains in the groins, especially the left, and in the back. Of late has noticed a swelling in her abdomen. Has had a brownish discharge for last six months. Complains of morning sickness, nausea, and pains in the upper abdomen after meals. No hæmatemesis; no increase in micturition; menstruation regular monthly, lasting a week, less copious, with pain for one or two days.

*Examination.*—The abdomen is distended at the lower part by a large, very hard mass, extending to within one inch of the umbilicus, and not mobile; no tenderness; a hard knob is felt in the right side, mobile. Rest of tumour smooth, and apparently wedged into the pelvis. *Per Vaginam:* Cervix high up and to the left. Body of uterus not distinguishable. Mass, filling both fornices, continuous with abdominal tumour. On bimanual examination, the tissue is very fixed, only very slightly mobile. On June 14th, I opened the abdomen by the usual incision, and, by means of a Doyen hysterectomy screw, with some difficulty lifted the tumour out of the abdomen, and removed it by the sub-peritoneal method. The patient made an uninterrupted recovery. On section of tumour it was found to contain several large sub-mucous, intramural and sub-peritoneal fibroids.

Mr. CHARLES RYALL said that Mr. Jessett was to be thanked for showing the giant myoma again, and for the further history of the case, especially as it had turned out unsuccessfully, for much more was generally to be learned from one failure than from many successes. Apart from the immense size of the tumour, the remarkable point was the extent and extreme intimacy of its adhesions to the abdominal wall. The cause of the gangrene was very obscure; the early onset of the symptoms contradicted the idea that it was due to bacterial invasion at the time of the operation. He thought that the gangrene might possibly be due to thrombosis of the common iliac extending down to the bifurcation and then along the external iliac, or to dislodgment of an embolus in the aorta, owing to the manipulation of the tumour at the time of the operation.

Dr. HEYWOOD SMITH mentioned that many years ago a patient of his did perfectly well after hysterectomy for nearly a fortnight after the operation, and then fell back dead while sitting up to have her dinner, the cause of her death being a pulmonary embolus. In that case the tumour had been a very large one. The occurrence of embolism after abdominal operation was a question of deep interest. Possibly it was more frequent in connection with large tumours where the blood supply was very large, and the vessels subjected to pressure, and perhaps to tension, at the time of the operation.

Dr. J. J. MACAN reminded the Fellows that though gangrene was uncommon, if not unique, after abdominal operations, it was by no means so after childbirth, affecting various parts of the body, but most commonly the lower extremities. In a recent number of the *Centralblatt* there were abstracts of articles on the subject by Schaeffer and Wormser, and both of them agreed in attributing it to infection. In Mr. Jessett's case it seemed that infection, if it had any influence, must have existed before the first operation.

Dr. RICHARD SMITH asked whether there had been any œdema of the leg, and what had been the after treatment.

Dr. MACNAUGHTON-JONES, jun., suggested that the pain complained of by the patient two hours after the operation could hardly have been due merely to local œmæmia, and that there might have been some pressure on the nerve as well as on the artery.

Dr. ROBERT BELL remarked that in a blood-vessel, so far as he understood it, coagulation could only occur

in the presence of a foreign body. In healthy blood-vessels coagulation would not take place, but inflammation in a vein or artery would act as a foreign body, and would produce the catalytic effect which caused the formation of a clot. In a case such as the one Mr. Jessett had brought before them, some injury might have occurred to either the innominate vein or artery, but if to the former the embolism would have been in the pulmonary artery rather than in the iliac, and he therefore thought that there must have been some lesion of the iliac artery to account for the clot.

Mrs. SCHARLIEB mentioned a case in which arrangements had been made to remove a very large fibroid, but two days before the proposed operation the patient was taken exceedingly ill with thrombosis of the left femoral vein, and the operation had to be postponed *sine die*. The patient had not suspected any phlebitis or other trouble in her leg, and there had not been any recent operation or manipulation in her case.

Dr. BELL explained that he by no means suggested that Mr. Jessett had injured the artery. Mrs. Scharlieb's case supported his own theory that the pressure of a large fibroid upon the iliac vessels might cause sufficient irritation to cause the formation of a clot, and thus produce the same effect as a foreign body.

Dr. MACNAUGHTON-JONES said that he did not conclude that there had been any injury to the iliac artery during the removal of the tumour. Large tumours pressing upon the great vessels of the pelvis undoubtedly sometimes affected these vessels injuriously, and it was more than possible that in the present case, especially considering the co-existent kidney disease, there had been an obstructive arteritis and that the manipulation necessary during the operation had loosened a clot already formed. He had himself shown pelvic tumours after the removal of which there had been œdema of the leg, inability to walk and other troubles.

Mr. JESSETT, in reply, said that there had not been before the operation any swelling of the legs, such as would naturally have been attributed to pressure of the tumour. The patient, it was true, had varicose veins, but not to any extent worth noticing. Pressure sufficient to interfere with the arterial circulation must, he thought, have interfered with the venous also, and would then have caused considerable swelling of the legs. Although the clot in the external iliac extended about an inch up to the bifurcation, the internal iliac was free, and it was difficult to understand why the collateral circulation was not sufficient to carry on the nutrition of the limb. In his opinion, the only explanation of that was that during the operation, perhaps owing to nervous shock, the woman lost very little blood, the general circulation was impeded, and the *vis a tergo* was insufficient to drive the blood through the leg, and a clot gradually formed which increased the difficulty. It had also crossed his mind whether the saline solution, of which the patient received a considerable quantity, had been absolutely sterile. There was no moisture in the gangrene whatever, the leg was simply dried up for want of nourishment. Dr. Macnaughton-Jones, jun., had suggested that there had been pressure on the nerve as well as on the blood-vessels to account for the pain. It was possible; we were all familiar with the sensation of "pins and needles" which supervened on the removal of pressure. Still in his own opinion, the arrest of the blood supply was the cause of the pain from the commencement.

Dr. HEYWOOD SMITH (Vice-President), having taken the chair,

Dr. MACNAUGHTON-JONES read a paper on ACCESSORY FALLOPIAN TUBES AND THEIR RELATION TO BROAD LIGAMENT CYSTS AND HYDROSALPINX, and showed some specimens illustrative of the origin of hydrosalpinx from accessory Fallopian tubes. Sampson Handley had criticised Kossmann's view that broad ligament cysts are neither parovarian nor cystic dilatations of the Wolffian diverticula or ducts, but are derived from accessory Müllerian ducts (sacroparasalpinx serosa). Handley and Shattock

had demonstrated from specimens in the College of Surgeons Museum the origin of accessory hydrosalpinx from the pronephric funnels of the Müllerian duct. Handley also showed that enucleable broad ligament cysts, developed above the tube, were derivable from accessory Fallopian tubes. Alban Doran had anticipated Kossmann in his surmise that such cysts were of Müllerian origin. Hamilton Bell, from the examination of a cyst removed by Cullingworth, supported Handley's contention. The histological analogy between the accessory and the ordinary hydrosalpinx was complete.

These histological analogies were typically shown in the first of Dr. Macnaughton-Jones' specimens. The cysts were derived from the Fallopian tube. The ovarian fimbria was absent, and its place was taken by two cysts.

The second specimen Dr. Handley reported to be undoubtedly an accessory Fallopian tube, the important point in this instance being that both the pedicle of the cyst and its wall were muscular, and the cyst was lined with ciliated and columnar epithelium.

The third specimen was very interesting, and though not microscopically examined, there was little doubt of the nature of the cysts. When one of these was held up against a strong light, the plicæ could be seen through its wall. In this instance there was a cyst in the free edge of the broad ligament, attached to which were two small flattened cysts, while hanging from the peritoneal folds there were two small cysts and an accessory Fallopian tube. These latter, Dr. Handley considers, represent in abnormal number the pronephric funnels. He also showed with the epidiascope other specimens illustrating the paper.

He exhibited a form of clip to which a small weight was attached by aluminium bronze wire, intended to supersede the use of forceps in keeping the cut edges of the peritoneum in position after opening the abdomen.

Dr. HEYWOOD SMITH said the only criticism he would offer of the cases described by Dr. Macnaughton-Jones was as to the word accessory. When speaking of accessory organs one had in mind an organ parallel in function to the one described, such as an accessory mamma or accessory kidney. He suggested that in the case mentioned by Dr. Macnaughton-Jones the word diverticulum or aneurysm of the duct should be used. They were really excrescences which seemed to be cut off, but evidently had the same foundation as the tube itself.

Dr. MACNAUGHTON-JONES said he could not agree with Dr. Heywood Smith in his criticism.

Dr. JERVOIS AARONS showed

#### A NEW UTERINE MOP,

reading the following note:—The difficulty and length of time wasted in removing the wool from the ordinary Playfair's probe after it has been used led me to try and devise some means by which the mop might be more easily and quickly removed. It occurred to me that a cap of some absorbent material which would fit over a conical sound would serve the purpose, and such a cap, or mop, I have had made; this slips over a conical or tapering metal sound, and is held in position by a small ring catch, which effectually prevents it from leaving the sound. The dry mops weigh 13 grains ('79 grammes); after being used they weighed 39 grains (2'5 grammes); they are, therefore, sufficiently absorbent for the purpose. The advantages over the ordinary Playfair's probe are: (1) Ease and rapidity of dressing the probe; (2) ease and rapidity of removing the mop after use; (3) they are easily sterilised; (4) the tapered part of the sound being made of plated copper can be bent to any desired shape. The caps and the probe were made for me by the Galen Manufacturing Co., Ltd., and I am indebted to them for the way in which they have carried out my ideas.

Dr. HEYWOOD SMITH concurred as to the difficulty in getting the cotton wool off the Playfair probe, unless one had the knack of rotating it in a direction contrary to that adopted when putting it on. The



present device was useful because the ring got on in its place.

#### THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

THE Provincial Meeting took place at Bristol on June 18th, Dr. THEODORE FISHER in the Chair. Prior to the meeting clinical cases were shown at the Hospital for Sick Children, St. Michael's Hill, and at the Medical Library, University College.

Dr. D. S. GERRISH showed some remarkable examples of "Progressive Muscular Atrophy" of the family type. He had been able to trace the disease back through five generations, and over forty members of the family had been affected. The usual history was that up to the age of 23 years the patients had been remarkable for their physique and muscular strength, but after that age the extensor muscles of the leg began to waste, chiefly the anterior tibials and the peronei. The condition slowly and steadily increased, and by the fiftieth year it had extended to the extensor muscles of the arms. Sensation had never been affected, but the reaction of degeneration was present. Although their hands were affected the patients retained their grip, but extension became very weak.

Dr. BERTRAM H. ROGERS read notes of a case of "Congenital Stricture of the Oesophagus." An infant, *æt.* about 2, began to suffer from vomiting, the condition getting rapidly worse, and being accompanied by emaciation. No definite physical signs of disease were present save much mucus in the lungs, and over-distension of the cervical veins on crying. Test meals showed that most of the food entered the stomach, but part seemed to be retained in the oesophagus. The use of X-rays and an oesophageal tube threw little light on the nature of the case. The child died from an increase of the bronchial trouble and dyspnoea. At the necropsy there was found a fairly tight stricture about an inch from the lower end of the oesophagus.

Mr. H. ELWIN HARRIS showed three cases—(1) "Congenital Absence of the Left Ear with Facial Paralysis"; (2) "Congenital Absence of the Left Eye with Cleft Palate and Hare-lip"; and (3) "Intra-uterine Amputation of Three Extremities, with Webbed Fingers on the Hand of the only Limb." The last case was a very remarkable one, as both legs were absent from 1½ inches below the hip-joint, and the left arm was removed flush with the shoulder-joint. On the stump of the right lower extremity was a very minute leg in which one could trace a rudimentary knee-joint, ankle, and foot. He did not know any satisfactory explanation of such deformities, and did not think that the theory as to amniotic adhesions was conclusive.

Mr. CLEMENT LUCAS expressed his disbelief in the theories current as to intra-uterine malformations such as maternal impressions, amputation by the funis, &c. He thought that if any satisfactory theory could be formed it would be one in which the nervous system played an important part.

Mr. GEORGE PERNET thought that such a theory as that of maternal impressions was a nuisance to science, and should no longer be tolerated.

Dr. J. MICHELL CLARKE showed a case of "Hydrocephalus" in which recovery had occurred. The illness probably began at the age of six months, and the patient had been under observation for some years. Intelligence had never been affected, but there had been marked weakness of the muscles of the trunk and lower extremities. After three years improvement set in, and the only traces of disease visible were the large size of the head and some signs of partial degeneration of the pyramidal tracts. The treatment had been by small doses of grey powder, continued over long periods.

Mr. C. A. MORTON read the notes of a case of HYDROCEPHALUS IN WHICH DRAINAGE OF THE VENTRICLES into the subdural space was established. The method of operation was that introduced by Mr. Watson

Cheyne, in which a communication is established between the distended ventricle and the subdural space, so that the fluid may be readily absorbed by the meningeal veins. The patient was an infant, *æt.* 7 months, suffering from congenital hydrocephalus. The first operation consisted in turning down a flap on the right side of the skull below the anterior fontanelle, and introducing a piece of fine rubber tubing, one end of which was passed into the ventricle and the other between the dura mater and the cortex. The flap of dura mater and membranous skull was then replaced and stitched carefully, so that all oozing had ceased at the end of twenty-four hours. On the eleventh day after the operation the head, which had been much smaller as the result of the operation, again showed signs of enlarging. A few months later the operation was repeated on the opposite side, the head still increasing in size. A small rectangular metal tube was first employed, but as the fluid would not flow through it, a rubber tube was inserted. Some leakage from the operation wound continued for a few days, and the cranial bones were over-riding. The temperature ran up to 105° on the evening of the tenth day, and the baby died. At the necropsy the brain was found to be lying about an inch from the cranium all round. There was no meningitis, and the drainage-tubes appeared to be acting well. Mr. Morton commented on the fact that although the drainage of the ventricle had been maintained continuously for two months after the first operation, yet the head had increased in size from excessive fluid pressure.

Dr. JAMES TAYLOR congratulated Dr. Clarke on the successful result in his case. It was not often that one saw a case of recovery from hydrocephalus, even after surgical measures, and for a case to recover after medical measures was rarer still. He had noted in some cases of recovery from hydrocephalus that the child seemed abnormally sharp and above the average in intelligence.

Dr. G. A. SUTHERLAND thought that recovery in cases of congenital hydrocephalus was not so very uncommon, the commonest underlying cause being syphilitic meningitis, and the cure being effected by a prolonged mercurial course. As regards the acquired cases, many of which dated from an attack of non-tuberculous basilar meningitis in infancy, he thought that medical measures were useless, and that the most hopeful line of treatment was by surgical intervention on the lines described by Mr. Morton.

Mr. CLEMENT LUCAS also viewed the condition of hydrocephalus as due to mechanical obstruction, and had made various attempts to remove the ventricular fluid. He had tried to drain the ventricle into the tissues beneath the scalp, but had not found absorption take place in that region. As regards other operative measures, it seemed impossible at present to descend to the base of the brain, but he thought advances would be made in that direction, for it was only necessary to let the fluid communicate sufficiently freely with its proper arachnoid space for the cases to be cured.

Dr. GEORGE CARPENTER agreed that many of these cases were syphilitic in origin, and had seen at least half a dozen of them cured by mercury and chalk.

Mr. J. LACY FIRTH showed a case of "Congenital Dislocation of the Hip," which had been under treatment by the Lorenz method for four months.

Mr. A. H. TUBBY thought that this method would only bring about cures in comparatively slight cases, namely, those in which the head was quite near to the acetabulum, and was of a good shape, and the acetabulum was widely open. The results, so far as they had gone, might be classified under three heads—(1) actual reposition, (2) good or fair results, (3) no result at all. He could not state the actual number of repositions, but it was comparatively small. The results which were good or fair were those in which the posterior displacement had been altered to an anterior displacement, but without complete reposition. Such patients walked better, some shortening disappeared, and they lost the lordosis. If anything like

excessive force was called for he thought that it was the surgeon's duty to desist, as when force was employed it was almost certain to result in a bad dislocation.

Mr. PAUL BUSH showed a child with extroversion of the bladder. A portion of the mucous membrane had "skinned over" under the constant application of a saturated solution of boracic acid. He proposed doing the old operation of turning over an upper central flap, and covering this by sliding two lateral flaps over it.

## British Health Resorts.

### III.—BUDLEIGH SALTERTON.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

ALONG the semi-circular sweep of the southern seaboard bounded by Portland Bill on the east and Start Point on the west, there are many places of merit as desirable health stations. Among these, Budleigh Salterton deserves mention. It is near to the estuary of the Exe and close to the mouth of the River Otter, and only five miles from popular Exmouth. It is a quiet little town of modern construction, which the extension of the South-Western Railway, opened in 1897, has made conveniently accessible. Well sheltered on the north it is less open to the south and south-east, and presents the usual advantages of a warm southerly seaside resort. The climate is mild and equable. The rainfall is moderate, the mean average of seven years being 26.82 inches. The soil is good and the roads dry speedily. Much sunshine usually prevails. Considerable improvement has been made to meet the needs of the health seeker. There is no pier or ambitious pavilion, but the front is conveniently laid out, and the visitor needing quiet and willing to lead a simple life will find much to attract on its cliff paths and inland wooded lanes. There are good golf links near at hand and the district is rich in drives, and offers many attractive walks. The water supply of the town is good and it is proposed to increase it. The drainage appears to be fairly satisfactory and it is proposed to carry the outfall sewer another 48 feet from the shore. (a)

Budleigh Salterton, with its population of about 2,000, is a desirable holiday resort for the wearied worker or town dweller, and it is very suitable for children. At present it cannot offer any very particular advantages for the luxury-loving invalid, but for the fagged brain and jaded body it can provide rest and means for enjoyable open-air life.

Dr. T. N. Brushfield, in his attractive little guide, claims that Budleigh Salterton is well fitted for the treatment of many cases of pulmonary consumption, the equable temperature and mild winters being particularly suited for the conduct of open-air life, so essential for the patients. "The climate benefits many cases of spasmodic asthma often modifying and lessening the painful attacks, especially in those who come from inland places."

Rheumatism is rare and rheumatic subjects, perhaps owing, at least in part, to the absence of a clay subsoil, do well. Cases convalescing from zymotic diseases should do well here. Delicate and rapidly-growing children will find ample opportunities for health-giving occupation out of doors. Invalids and aged will find the peace and quiet peculiarly attractive. Efforts are being made to develop Budleigh Salterton as a winter resort.

The hotel accommodation is at present somewhat limited, but furnished apartments in good positions can usually be obtained. Budleigh Salterton is easy of access. It is 170 miles from London and is reached by the London and South-Western Railway, *via* Sidmouth Junction and Tipton St. John, or through Exeter and Exmouth. During the summer months a fast train leaves Waterloo at 11.20, reaching Budleigh

Salterton at 3.59. Fortunately for the peace and quiet of this desirable resort there is no Sunday service of trains.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 24th, 1904.

### POISONING BY CAMPHORATED NAPHTHOL.

M. GUINARD sounded a cry of alarm at the meeting of the Société de Chirurgie, *à propos* of injections of camphorated naphthol. A patient, *æt.* 28, of otherwise healthy appearance, entered the hospital for a voluminous cold abscess on the right side of the neck. The purulent collection was tapped with Potain's apparatus, giving issue to a certain quantity of pus, which was immediately replaced by an ounce and a half of camphorated naphthol, introduced by a cannula. Five minutes after, the patient was seized with epilepsy, initial cry, biting of the tongue, sanguineous saliva from the lips, clonic spasms followed by tonic spasms, with general stiffness and threatening asphyxia. After several struggles, the patient succumbed, in spite of every artificial means used in such cases.

After this accident, M. Guinard searched in medical literature for any similar cases, and found eight deaths and fourteen cases of grave poisoning. Now this agent is very frequently employed by practitioners for tuberculous ganglions. Of the eight fatal cases collected by M. Guinard, four were previously published, and in no case was it possible to incriminate the quality of the liquid injected nor the dose employed. In the fatal cases cited the dose was 5 c.c. in two patients, in others 10, 20, or 25 c.c., and in one only  $\frac{1}{2}$  c.c. was used.

The symptoms of poisoning were generally the same, epileptic seizures, convulsions, fainting, face congested, with respiratory trouble, arhythmic pulsation of the heart, death.

These symptoms occurred very rapidly after the injection—from a few minutes to three-quarters of an hour. In five of the above cases they were observed two minutes after the injection. Death followed in ten minutes in one case, and one, two, or three hours in the others.

What is the toxic agent? asks Dr. Guinard. Is it the naphthol, the camphor, or the mixture of both these agents?

Numerous experiments were made on animals to find an answer to this question, and the following conclusions were arrived at:—

1. Camphorated naphthol possesses toxic properties.
2. The camphor alone produced the symptoms of poisoning, as camphorated naphthol represents an intimate molecular combination, and that the camphor was more soluble than naphthol; it is, therefore, rational to attribute to the camphor the symptoms observed.
3. It is demonstrated that camphorated naphthol is more toxic than spirits of camphor, camphorated oil, or naphtholated spirit taken separately.
4. As naphthol alone is toxic to some extent, it may be inferred that when combined with camphor the toxic properties are greatly increased.

In face of such evidence, M. Guinard rejects systematically all preparations of camphor and naphthol, regarding them as highly dangerous and by no means indispensable to the cure of tuberculous ganglions.

### DIAGNOSIS OF ATAXY.

The incipient stage of ataxy, says Dr. Milian, is extremely insidious, or hidden behind some functional symptoms leading the unwary astray. One patient

(a) "Summary of the Reports of Medical Officers of Health for South Devon" (1902). By William Harvey, F.R.C.S. Exeter: Devon County Council Offices, 1903.

will complain of lancinating pains, which he attributes to rheumatism; another of gastric trouble resembling ulcer of the stomach, and so on. Yet it would be of the greatest interest to the patients if the diagnosis of locomotor ataxy were affirmed at the outset, as, if the mercurial treatment has any chance of success, it is at this stage only. To reach this end it is necessary that the syphilitic patient be followed more or less for five, ten, or fifteen years, and that he should pay periodic visits to his physician to have his nervous system examined. It is for the physician to watch for any symptoms of ataxy.

The examination should bear upon the sensitiveness of certain regions, the reflexes and the condition of the muscles.

Sensation to pain is the most important symptom to study, and a simple pin is sufficient for the purpose. The regions more or less insensible to pain are the little finger, the soles of the feet, and the breast, both in man and woman. There is generally also delay in the perception of the sensations, especially observed in the points furthest from the centres.

The muscular sensation is also affected at the incipient period of the disease; the patient loses the notion of the position of his limbs. In placing one leg over the other in the bed, the patient is unable to tell, eyes closed, their respective positions. In the upright position, the loss of muscular sensation is revealed by the impossibility of maintaining the equilibrium with closed eyes. This sign, known as that of Romberg, can present every degree, from simple oscillation to falling. This sign affects, but to a lesser extent, the muscles of the trunk and the arms. If the patient lies on his back, the legs and thighs drawn up and embraced by the two arms, he will roll to the right or left in his bed as soon as he shuts his eyes.

These different troubles of the cutaneous and muscular sensitiveness should be sought for with care as they are very important in the diagnosis of ataxy.

As regards reflex action, that of the skin is of but indifferent importance, but it is quite otherwise with the tendons, for its abolition is one of the cardinal signs of the malady.

It was for a long time believed that the abolition of the patellar reflex (Westphal's sign) was the first symptom of ataxy, and to a certain extent the idea was correct, but Babinski has shown that the abolition of the reflex of the tendon of Achilles was still more important. It consists as follows: The patient kneeling on a chair, the Achilles tendon is smartly struck above its insertion. The gastrocnemius muscle contracts, producing extension of the foot. One should not be contented consequently, as often happens, to strike the knees of a patient, and because the patellar reflex is present conclude that the patient is not ataxic. An individual can be affected with the disease with the patellar reflex intact, if that of the tendon of Achilles be abolished.

The examination of the patient terminates with the search for the sign of Argyll-Robertson, which consists in the disappearance of the contraction of the pupils in the light; this sign is of great value. Dufour performed an autopsy on a man who had presented the sign of Argyll-Robertson as the only clinical symptom of locomotor ataxy, and he found the anatomical lesions of the malady of Duchenne, that is to say, sclerosis of the posterior roots.

With this systematic exploration of the patellar and Achillian reflex, luminous reflex, sensitiveness of the sole of the foot, the mammary region and the little finger the malady can be recognised at its outset.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 24th, 1904.

At the Surgical Congress Hr. Beck, Carlsruhe, spoke on

### CHRONIC COLITIS AND ITS TREATMENT BASED ON SURGICAL EXPERIENCE.

He said that in chronic colitis the accompanying nervousness was not its cause, but a secondary symptom. The patient could not maintain the diet recommended. He had seen and treated for months and years 500 cases (170 men and 330 women). The most important thing was the recognition of the etiological factor, and the treatment must correspond to this. The causes were (1) Diseases of the appendix, the gall-bladder, the other abdominal contents, the uro-genital organs. He had seen 149 such cases. (2) Circumscribed diseases in the colon, such as carcinoma (31 times), tuberculosis (7 times), actinomycosis (twice). (3) Acute gastritis, alcoholism, nicotinism and other harmful effects on the stomach, such as gastroptosis. The majority of cases were those of women suffering from uro-genital affections and changes in the abdominal interior from pregnancies; 257 cases were treated successfully by operation. Of the 243 cases not operated on operation was recommended but declined in 120. No improvement had taken place in these cases. Cases caused by abuse of alcohol and tobacco, cirrhosis of the liver and chronic nephritis were not cured. In six cases the whole of the colon was put out of action by ileo-sigmoidostomy. Five of these cases were cured; one in which Murphy's button was employed died.

At the Society f. innere Medizin, Hr. A. Plehn reported

### TWO CASES OF TUMOUR OF THE CENTRAL NERVOUS SYSTEM.

The first was that of a young woman, æt. 23, who had passed through the usual illnesses, had suffered from visual disturbances for a long time after diphtheria, but had finally lost them. From her childhood her voice had been nasal, hearing on the left side was bad, and she had been anæmic for a long period. In January, 1903, she had a child which was healthy but had snuffles. There were no symptoms of syphilis. Since March, 1903, she had complained of headache, which extended from the forehead to the occiput, and was accompanied by vomiting. There were loss of appetite, wasting and weakness of sight. She was admitted into hospital in September last. Examination showed swelling of the inguinal glands and those of the neck, slight difference in the pupillary reaction and broad nodules in the skin of the abdominal wall and over the scapula, which were believed to be fibromata. The nervous system was otherwise sound. An ophthalmological examination showed changes in the fundus oculi, the papillæ were only recognisable by the course of the vessels, slight clouding. As these symptoms roused a suspicion of syphilis, pot. sod. was given, and as some improvement appeared to follow it, the dose was raised to 7 grms. pro die and inunction was begun. After this the general symptoms improved very much, and particularly those in the fundus oculi. Syphilis was now thought certain. The patient was discharged from hospital, but reappeared two months later with the condition very much worse. She complained of violent headache, especially in the neck, and of great disturbance in hearing and seeing. Examination showed the same condition as before, but with perforation of the left tympanum; there was also purulent

catarrh of the middle ear, although there was none when she was in hospital before. The former diagnosis of syphilis could not therefore now be maintained, the symptoms pointed rather to tumour in the brain and probably in the posterior fossa. Potassium iodide was again given as it was also useful in tumours that were not specific, with improvement in the symptoms. Lumbar puncture showed an intraspinal pressure of 400 mm. of mercury, which sank to 270 when 8 ccm. of cerebro-spinal fluid had been drawn off. Still violent headaches and vomiting came on. On puncture a few days later the pressure was reduced from 270 mm. to 110, when serious trouble arose. In one night following there was extreme collapse. Two days later there was sudden extreme difficulty of swallowing and bulging forward of the right velum palati and the right part of the wall of the pharynx. These symptoms gave rise to a suspicion of pus; they subsided to some extent, however, later and remained stationary from February to June 22nd last, when the patient died from collapse. During the whole course of the disease there were no disturbances of the nervous system, except towards the last slight facial paralysis.

The second case was that of a man who was admitted into hospital on June 3rd in a state of stupor. So far as could be got out of him he had had a stroke about three weeks before. There was slight left-sided paresis, circumscribed œdema of the face, nose, forehead, and both eyelids, the veins of the skin in the parts dilated and tortuous. Later on there was blocking of the ophthalmic vein at the base of the orbit, and it was assumed that the compression was caused by a neoplasm. Lumbar puncture was performed, but scarcely any fluid escaped, possibly in consequence of obliteration of communication from the brain to the cervical canal by a tumour. The urine was normal. Eventually the man died.

Hr. Bender observed that the chief interest of the cases rested on the slight correspondence between the clinical symptoms and the anatomical condition. In the first cases there were widespread tumours in the peripheral and central nervous system, and in the second carcinose necrosis of the skull, but no tumour in the brain itself. The tumours in the first case were fibro-neuromata, the chief tumour being in the meninges of the cerebellum.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 24th, 1904.

### THEORY OF THE STREPTOCOCCUS SERUM.

At the Congress for innere Medizin, Menzer drew attention to his sera of streptococci, which he had not transmitted through animals before applying them to acute rheumatism with excellent results. They are especially useful in that form of transmissible rheumatism. He has recently applied some of this serum in mixed tuberculous cases with equally good results, but he would like to have more experience in the latter before dogmatizing on the subject.

Aronson thought that the febrile reaction obtained by Menzer was due to the transmission of a toxin into the system. The serum used by himself caused no fever.

Wolf was of opinion that the fever might be the result of an endotoxin.

Michaelis asked Menzer if he used the same serum for articular rheumatism as he did for the tuberculous cases. If this were so there must be a great difference

in the streptococci, as the purulent result of tubercle is very different from articular rheumatism, where no pus ever occurs.

Menzer said the serum from the same animal contained different streptococci. If Aronson got no reaction or fever with his serum the probability is that it was below the necessary strength!

### CROUPOUS PNEUMONIA.

Stuertz gave a history of his experiments with the sputa of croupous pneumonia on white mice, which died in the same manner. The virulence and clinical symptoms were the same in both mice and men, which led him to believe that this test might be of prognostic value in forecasting the result of a case when the attendant is placed in the difficult and doubtful position of depending on the varying symptoms that are usually manifested in these doubtful cases, where one exacerbation after another points to intervals of morbid progress and ultimate exhaustion.

### HEPATIC LEVULOSE UREA.

Strauss said that he had examined upwards of a hundred cases with levulose in the urine, and found that 80 per cent. of these cases suffered from hepatic disease, which left 20 per cent. for genuine alimentary levulose. Sachs, under his own guidance, had demonstrated that with levulose in the muscles no distinction could be discovered between glycogen and dextrose. Again, Schrot was unable to isolate levulose from a mixture of pancreas and muscle, while dextrose was easily distinguished. He concluded from these results that the synergia of muscular movement had no part in the production of levulose. This was diametrically opposed to Schlesinger's experiments on dogs. He found that it was easier to obtain the levulose product than dextrose. Whatever the cause may be in dogs, the hypothesis is negatived in man.

### OCULAR SYMPTOM IN DIABETES.

Krause drew attention to hypotonia, or peculiar ocular symptoms in diabetic coma that are never generally acknowledged, which appears about fifteen or thirty-two hours before death. This symptom does not appear in morbus Basedowii, Addisonii, uræmia or other febrile attacks of an obscure nature, where sudden comatose conditions often arise and may require to be differentiated. It presents itself in both bulbi, but how to explain it Krause would not presume to hazard an opinion. He had to admit exceptions, as in eighty diabetic cases of coma that ended fatally eighteen had no hypotonia during life. He suggested that the symptom might be caused by low pressure in the blood-vessels produced by hydration or hæmatic dyscrasia. This hypothesis could not be borne out by experiments on animals, as dogs treated with acetone, acetic-acetone-ester,  $\beta$ -oxybutyric salts, and phlorodizin never had the symptom during life, although the drugs administered had been used differently, sometimes by the mouth, at other times subcutaneously. Other dogs had the pancreas removed, the animals dying of diabetes; but no hypotonia was present at any time. The anatomical examinations of the bulbi revealed no morbid condition in the eye itself.

### MOTOR FUNCTIONS OF THE VAGUS.

Starck gave the results of his research on the motor function of the vagus. The elements in this phenomenon were cardio-spasm, paralysis of the œsophageal muscles, and atrophy of the vagus. He divided his experiments into two positions, *viz.*, resection of the nerve above the hilus, or division of nerve into the lung, and that below the hilus. Section of the nerve always removes the inhibitory action on the cardia, but this is not of long duration, and must be considered temporary.

Resection of the nerve below the hilus of the lung produced no dilatation of the œsophagus; neither did it cause any weakening of the heart. When the section was made above the hilus, on the contrary, dilatation and tachycardia resulted. Vagus atrophy may therefore be charged with producing dilatation of the œsophagus when no hypertrophy of the muscle is found, as a paralysed muscle is not likely to become so. He concludes with the assertion that when we meet with hypertrophy and dilatation in the œsophagus we may affirm that the cause is not degeneration of the vagus.

### The Operating Theatres.

#### CHELSEA HOSPITAL FOR WOMEN.

**ABDOMINAL PANHYSTERECTOMY FOR CARCINOMA OF THE BODY OF THE UTERUS.**—Dr. A. GILES operated on a woman, æt. 53, with the following history: Six weeks before admission she had been under the care of Dr. Townsend Barker, complaining of hæmorrhage, for which he asked Dr. Giles to see her. The uterus was found at that time only slightly enlarged, and it was decided to dilate the cervical canal and explore the uterine cavity, as there seemed to be a probability of carcinoma of the body of the uterus. This was done, and some rather soft fragments were removed by the curette; they were sent for microscopical examination and report to the West End Pathological Laboratory, and Mr. Eastes reported that the growth was carcinoma. It was then decided that she should go into hospital for hysterectomy. The patient, though married, had had no children, and the vagina was rather narrow. In view of this fact and of the situation of the growth in the body of the uterus, the abdominal route was decided upon. The operation performed was panhysterectomy by Mr. Bland-Sutton's method, and both appendages were removed in one piece with the uterus. The method referred to is as follows: The broad ligaments are clamped off with forceps in the usual way and divided up to the side of the uterus, the uterine arteries are seized with forceps, the bladder reflection is turned down in front, and a small peritoneal flap is fashioned behind. The uterus is divided just above the point where the uterine arteries are seized, but the line of division, instead of being carried straight across the uterus as in the ordinary supra-vaginal amputation, is made to pass downwards and inwards on all sides, so that eventually the vagina is opened and all that is left behind of the cervix is a thin outer shell, and the portion removed shows a tapering lower extremity tipped by the os externum and a small portion of the vaginal mucosa surrounding it. The arteries are then tied off, and the peritoneal flaps brought together by a continuous suture of fine silk. The abdomen is closed by the usual triple layer method. Dr. Giles said that this case was a very suitable one for the method employed, because this allowed for the complete removal of the uterus and appendages in one piece, and much more satisfactorily than could be done by vaginal hysterectomy. When carcinoma affected the cervix it was of course necessary to remove the whole of the vaginal covering of the cervix, and this could be done properly from the vagina, but in a case where the growth affected the body of the uterus the removal of the vaginal covering was less important than free removal of the broad ligaments. The advantage which Mr. Bland-Sutton's method of panhysterectomy presented over other methods was that as the dissection was carried out within the outer capsule of the cervix, there was no possibility of injuring the ureters or the bladder. The method was devised for dealing with uterine fibroids, but was useful also

for cases of carcinoma of the body of the uterus. The whole organ in this case was small, affording an example of that interesting class of case in which carcinoma develops in an atrophic uterus after the menopause.

The patient made an uninterrupted recovery, and left hospital on the seventeenth day after operation.

#### ST. GEORGE'S HOSPITAL.

**OPTICAL IRIDECTOMY.**—Mr. H. B. GRIMSDALE operated on a girl, æt. 25, who had been suffering from severe recurrent iritis, as a result of which the iris became totally adherent to the lens and the pupil blocked with lymph. Mr. Grimsdale pointed out that an operation was necessary for two reasons: in the first place, to re-establish communication between the posterior and anterior chambers and thus to prevent the onset of secondary glaucoma, and, in the second place, to form a new pupil, since the natural one was useless for visual purposes owing to the lymph on the lens capsule; vision had been reduced in each eye to recognition of the movements of the hand at two feet distance. He also said that this necessity governed the choice of operation, as ordinarily to prevent glaucoma the surgeon would make his coloboma in that part of the iris which would be covered by the upper lid; but here it was necessary that the gap in the iris should be exposed. Mr. Grimsdale made an incision with the keratome, having an extent of about eight millimetres in the lower and outer quadrant of the cornea; he then introduced a pair of Dr. Wecker's scissors closed through the wound until the points reached the pupil. Then they were allowed to open slightly, and a small fold of iris sprang up between the blades. On closing the scissors this fold was cut off and withdrawn with them. The same operation was then performed on the other eye. A drop of atropine solution was instilled into each eye, and a pad and bandage applied. Mr. Grimsdale said this was a form of operation devised by Mr. Brudenell Carter, but not very frequently performed. It seemed to him by far the most suitable for such cases as the present. The size of the artificial pupil and its position could be selected, and varied at the surgeon's will. It was most important for good vision that the iridectomy should be small, and he reminded the onlookers that a small iridectomy suffices in secondary glaucoma. If the iris be drawn out of the wound with forceps the fold that is cut off is necessarily larger than the part excised in the method he had employed, and, further, the natural pupil is often partially freed from its attachments to the lens so that two functional pupils remain, giving rise often to diplopia. It had been objected to the method that a wound of the lens capsule, and consequent traumatic cataract, was not unlikely. If the points of the scissors were allowed to enter the pupillary region such an accident might occur, but, if they were kept, as he advised, outside the pupil, it was difficult to see how such a *contretemps* could happen. As to the result of the operation, he referred to a case which had been treated in this way two months previously. The patient, a boy, æt. 12, had a similar defect in his left eye to that of the present patient. His vision was only capable of counting fingers at two feet distance. A fortnight after the operation it had risen to  $\frac{5}{6}$ .

#### Exposing a Scarlet Fever Patient.

At Malvern, Frank Ganderton, of independent means, residing at Malvern Link, was summoned at the instance of the District Council for failing to notify that his son, aged five years, was suffering from scarlet fever, and also for exposing the child to the danger of the public health. The evidence showed that the child was in bed for a week, was sick, had sore throat, swollen glands, and rash. Whilst in the desquamating stage the child was sent to school. The parents swore that they had no suspicion of scarlet fever. The Bench inflicted a fine of £2 and costs.

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 27, 1904.

**THE DIMINISHING BIRTH-RATE.**

THE birth-rate of any given community clearly affords data of great value as regards the moral and materia' welfare of its citizens. It does not follow, however, that the significance of variations in the birth-rate is always rightly interpreted. So far as that goes, indeed, the whole matter appears to be on the borderland where laws are beginning to loom from the dense mists of half knowledge and speculation. Hence it is in the highest degree desirable that the laws which govern the birth-rate should be freely and adequately discussed by competent observers. Unfortunately, the subject has been generally tabooed because of its close relationship with the prevention of conception among married folk. If that be a great social evil, as many moralists would have us believe, it is surely a mistaken policy to ignore its existence. The sounder attitude of our moral teachers would be to gauge as far as may be the true inwardness and the full relations of that particular practice before arriving at a working decision. The Church has ignored prostitution, but that vice stalks rampant through our streets, and exacts a terrible toll of misery and destruction from the innocent as well as from the guilty. But signs are not wanting that the clergy of the United Kingdom are ready to speak out upon the birth-rate question. The Bishop of Ripon and other distinguished churchmen have spoken publicly upon the decline of the birth-rate, as brought forward by Dr. Taylor, of Birmingham, in an address published in our own columns in March of the present year. The publication of that article has given rise to universal interest and discussion in all classes of society. The main conclusion was that the decline of the national birth-rate was due to practices of prevention among married persons, and that the unfortunate practice in question was attended by

evil results both physical and moral. Great credit is due to Dr. Taylor for his courage in bringing forward a difficult subject in so clear and delicate a way. His article raised momentous issues, and was clearly inspired by a strong personal sense of social and moral obligation. His audience was primarily medical, and his communication published in a medical journal. His views, however, have not been allowed to pass unchallenged by his own profession. His contentions are analysed critically and discussed in two articles by Dr. David Walsh, published in the issues of THE MEDICAL PRESS AND CIRCULAR for July 13th and 20th. It is impossible to enter at length into the various points raised in the second paper. Briefly, Dr. Walsh admits that there has been a fall of 5·2 per 1,000 persons living during the past half century. At the same time he says there is no evidence to show that the fall is due to a condition exclusively affecting married life. A similar decrease of births has affected illegitimacy, a fact not considered by Dr. Taylor; yet that, taken with the ever-increasing later period of the marriage age, would together account for a great deal of the fall. The birth-rate of 1900, again, is practically the same as that of 1840. Thirty years of rapid increase were followed by thirty years of fall. Is it possible that the United Kingdom is nearing its limit of supportable population, and that the falling birth-rate is a delicate index of waning prosperity? There is little doubt that preventive methods prevail in the higher ranks of society. Probably it is only a question of time for similar practices to permeate to the poorer classes. A crucial question is how far this kind of "intellectual limitation" of families overlaps the moral obligations of the citizen. The subject is one of the most complex, and at the same time most important, that could engage the attention of the social, the scientific, and the moral reformer. In our opinion, Dr. Walsh deserves careful attention when he suggests that the soundest remedy for a waning birth-rate may possibly or probably be found in laws that lead to greater equality in the distribution of wealth, and of opportunity to the individual citizen.

**IS A HOMŒOPATH A QUACK?**

AN interesting libel action was lately tried in Germany, the plaintiff being Dr. Mende-Ernst, a homœopathic practitioner of Zürich, and the defendant Dr. Spartz, the editor of the *Muenchener medizinische Wochenschrift*. Dr. Spartz's journal had published an article in which Dr. Mende-Ernst was referred to as "the well-known charlatan and homœopath," a conjunction of designations to which the latter look strong exception, so much so that even after Dr. Spartz had published an announcement that Dr. Mende-Ernst was a duly qualified medical graduate of Zürich he found himself sued for libel by the indignant homœopath. A number of witnesses, including von Winkel, the great authority on forensic medicine, were called by the defence to show that,

however well a man might be qualified in the view of the law, from the point of view of scientific medicine he deliberately placed himself on a level with charlatans when he embraced and practised the exploded system of Hahnemann. von Winckel quoted the amusing dictum of Müller that the principles of homœopathy seemed to him to be about the same as if after a man had been run over by a wagon he should be treated by having a toy-cart run backwards and forwards over him three times; and he showed, moreover, how homœopathy is used to hoodwink and deceive the public, just as much as frank charlatanism is. Spartz, in his evidence, dwelt on the fact that homœopaths were in reality worse than quacks, in that they had been instructed in the scientific basis of medicine and had eschewed it in favour of ridiculous doctrines, such as that the "intellectual vital force was dynamically out of time," and that it was inconceivable that any man who had been taught pathology could act so from conviction. The other scientific witnesses spoke to the same effect, saying that from the point of the profession homœopaths rank as quacks. As it happens, however, the Bavarian law recognises homœopaths, and in the end the editor had to pay a nominal fine and costs, although it was clearly established that there was no question of personal malice. For a long time past the homœopaths, in this country at least, have been holding out the olive branch to those whom they are pleased to call "allopaths," or "antipaths," for they are tired of being cold-shouldered by the self-respecting members of the profession, and they are willing, as expressed by the mouths of some of their leading spokesmen, to give up their sectarian character. No doubt it would suit them well to be able to meet scientific physicians in consultation in dangerous cases, and to have eminent surgeons to operate on their patients when they are in difficulties, so long, that is, as they can retain the hold that they have on the section of the public who see magic in the blessed word "homœopath." But the homœopathic practitioner cannot have it both ways, and while he professes to practise a hole-in-the-corner system he cannot expect scientific men to meet him and recognise him as one of themselves. In this country, as in Germany, it may not be legal, or even scientific, to call a homœopath a "quack," if a quack is taken to be "a boastful pretender to medical skill that he does not possess," but the gulf that separates the man who holds the pathology of disease to be the basis of rational treatment from one who holds that pathology is irrelevant to treatment, and that the "vitality of symptoms" is the true guide to the prescription, is one that cannot be bridged. The homœopath of to-day is certainly very far removed from the enthusiast who held that the "itch was the cause of seven-eighths of all chronic diseases" and that "by the trituration and succussion of drugs there is an actual exaltation of medicinal power, a real spiritualisation of the dynamic property, a true, astonishing unveiling and

vivifying of the medicinal spirit." They have indeed given their master the go-by in almost everything; they do not scruple to use remedies that confessedly act on allopathic principles, and they admit the virtues of such a radical antipathic ally as surgery. In fact the homœopath now is very much of an eclectic, and when he hears a method of treatment is doing good he does not wait to see if its acts on the "similia similibus" or the "contraria contrariis" principle before adopting it in his practice. He reserves his globules of bryonia and his pilules of pulsatilla for old ladies who have not much wrong with them, and for children who will get well if not treated much with anything, and if taxed with inconsistency, he will exercise a deal of casuistry to show that a potent treatment, such as antitoxin in diphtheria, is quite admissible under homœopathic rules. Indeed, the most wonderful thing about the modern homœopath is his aptitude for sophistries, and the amount of ingenuity he can expend on showing that in spite of all appearances he remains a homœopath is worthy of a better cause. But in so far as the homœopath is removed from a quack and approaches to "allopathic" standards, it is difficult for the unsophisticated to believe in his disinterestedness, and, quack or no quack, it behoves the medical profession to give him a wide berth while he continues to obtain practice on the pretence of having some esoteric principle up his sleeve. When he confesses that he is prepared to drop his sectarian title and to do what is best for his patient, irrespective of system or creed, it may be feasible to absorb him into the general rank of the profession. But that day is not likely to come in this generation.

### Notes on Current Topics.

#### Hypnotism in the East.

THERE is no doubt that Oriental medicine has not received all the attention it deserves from Western inquirers. Eastern civilisation has been for so many centuries stationary that all old beliefs, being freed from that healthy spirit of scepticism which is necessary for the preservation of truth in its purity, have naturally become crusted over to such an extent as to render their meaning obscure and their value indeterminate. To multiply metaphors, as Sancho Panza does proverbs, there is but a halfpenny-worth of bread to an intolerable deal of sack, or, in plainer language, a grain of corn to a bushel of chaff. Still, to the curious there is often much interest in turning over the chaff to find the grain, which may be, moreover, a good sound one when discovered. Several of what in these countries and in our new civilisation we are accustomed to consider most modern methods of treatment have, in fact, been known in the East for ages. Readers of "Kim" will remember Mr. Kipling's description of massage as practised in India, and as it was practised there centuries before its introduction into Western therapeutics. Indeed, we cannot but notice the



similarity between the treatment undergone by Kim after his exhausting journey and the method of treatment associated with the name of Dr. Weir Mitchell. Similarly, the induction of anæsthesia for surgical purposes is part of the old knowledge of further India, while many of the phenomena of hypnotism, known to us here only in this generation, have been made use of for all sorts of purposes "east of Suez" as far back as history goes. In the Malay Peninsula the hypnotic state is known under the name of *latah*, and is clearly recognised by the natives. Dr. Percy Gerrard has recently reported (a) an interesting case which came under his own observation, in which the hypnotic state could be easily induced by giving the patient a sudden shock of any kind. An unexpected clapping of the hands, a shout, or a poke in the ribs was sufficient to reduce the patient, a young and intelligent Javanese woman, to the condition. The duration of her paroxysm was in direct proportion to the period of continuance of the excitement, but usually, when left alone, she quite recovered herself in about half an hour. While in the condition of *latah* she scolded and jabbered in violent and meaningless language, but was entirely amenable to commands given her by bystanders. We hope Dr. Gerrard will be able, as he promises, to pursue his researches further into this interesting condition, and its occurrence in the Malay.

#### "Single Cases" of Lunacy.

THE report of an inquest at Battersea last week shows, if demonstration be needed at all, the necessity for some such measure as that which the Attorney-General is trying to pass into law this Session. This Bill, which has already been commended in our columns, seeks to give power, on single medical notification, for a patient who shows signs of mental aberration to be placed for a period not exceeding six months in the private house of a medical man for observation and treatment. Such a measure meets those cases of slight mental disease which need care and supervision, and which a medical man hesitates to certify as insane and send to an asylum. In the instance under notice, a Miss Ellen White first developed some delusions on May 16th, and Dr. Needham, of Clapham Park, was consulted. He advised her sister that she was insane and should be removed to the infirmary, but the sister was shocked at the idea, as relatives always are, and it was arranged that Dr. Needham should try to get her into a licensed house. This, however, could not be managed, and eventually she was taken into a private nursing home at two guineas a week. Under a course of bromide she became rational in the course of a fortnight, but great weakness set in, and she was eventually removed to the infirmary, where she died. The Coroner closely examined Dr. Needham as to the insanity, and he stated, in reply to the questions, that he was not certain that she was a lunatic, and that he did not care to fill up a certificate

on the evidence he found; moreover, that it was a common custom to keep patients in a home prior to certifying them. After hearing the witnesses, Mr. Troutbeck proceeded to make some strong remarks as to the propriety and legality of keeping a lunatic in an unlicensed house, and the jury, in finding that the death was from natural causes, expressed the opinion that a further inquiry should take place. No better example of the difficult and delicate situation in which medical men so frequently find themselves placed could be given than this; nothing shows more plainly the urgency for legalising the practice of providing a half-way house for slight and incipient cases of insanity. The fact that in this particular instance some doubt is thrown on the skilled nature of the nursing does not invalidate the general proposition.

#### A Historic Drug House.

THE announcement that Messrs. Francis Newbery and Sons, of Charterhouse Square, have converted their business into a limited liability company recalls some interesting particulars with regard to the history of a mercantile concern which, by reason of its antiquity, is, we think, unique in the drug trade. It is almost one hundred and sixty years since John Newbery, a seller of drugs at Reading, came to London and started business in St. Paul's Churchyard. In the same year we find him entering into a contract with Dr. James for the sale of his famous powder. He and his son Francis seem to have early acquired a reputable name among the citizens of London, and we find them on terms of intimacy with Dr. Samuel Johnson, for the great lexicographer is noted as being present at a house-warming given in 1779 by Francis Newbery on his removing into another house in St. Paul's Churchyard. This was the second move made by Newbery's business, without leaving the Churchyard, but it now remained in the same house for exactly ninety years. Between 1869 and the present, however, no less than three changes have been made before reaching its present quarters. The directors of the new company are the great-grandsons of the original John Newbery, and the concern has descended regularly from father to son through its whole history.

#### Magnetic Opium.

THE subject of hypnotism and its allies has always been one in which our French *confrères* have taken the keenest interest, and marvellous indeed were the tales—they have not been so common of late—that used to emanate from the cliniques of their neurologists. Since Mr. Ernest Hart went over to investigate some of the phenomena that were reported, and returned home with a somewhat modified opinion of the perceptive acuity of their authors, things have been quieter. But now and again astonishing stories still appear, and they certainly make interesting reading, if nothing else. In the *Revue de l'Hypnotisme* a tale is told of a young woman

(a) *Dub. Journ. Med. Sci.*, July, 1904.

—most of the subjects are young women—of a restless, impulsive, jealous disposition, who had taken to the opium habit. Far from aggravating her awkward traits of character, and leading her to moral ruin, the opium seemed to act like a charm; she became quiet and demure, careful and economical; in short, a pattern of all the virtues. Instead of being thankful for the change, she was so ungrateful as to give up the drug, and, hey presto! back came the jealousy, the restlessness, the extravagance. Obviously this was a disadvantage, and this erratic young woman determined to subdue her evil tendencies by resorting to opium once more. Welcome success attended her. She became shrewd and cautious, quiet and sedate, reason and reflection yet again characterised her dealings with her fellow-creatures. The *Revue* ingeniously points out that the question would arise in the psychologist's mind whether her morphine personality was not superior to her natural self. But why to the psychologist's only? Would it not be patent to every man with a brain in his head that this elegant young lady's salvation lay in her becoming a confirmed morphinomaniac? We fear if it is revealed to the world that opium has this Dr.-Jekyll-and-Mr.-Hyde effect, a good many people will take to putting laudanum in the drinks of their objectionable relatives to see if they could not be transformed into amiable and lovable creatures, just as anti-dipsomaniac cures are recommended to be slipped into the inebriate's glass when he is not looking.

#### Jaundice and the Widal Reaction.

EVER since the agglutination test, incorrectly ascribed to M. Widal, has come to be relied on in the diagnosis of typhoid fever, exceptions to its application have been noted. On the one hand, certain cases clinically indistinguishable from typhoid fever, but failing to respond to the agglutination test, have occurred. These have now been recognised as forming a distinct entity, not only due to a different organism, but with definite pathological differences, and have been grouped under the common term "paratyphoid fever." On the other hand, a clumping reaction sometimes occurred with blood which came from patients to all appearance free from typhoid fever. In some cases this has been explained by the fact that the patients had in time past suffered from the disease, and the blood had retained its agglutinating power. In others it would seem that the blood has congenitally an agglutinating action towards the typhoid bacillus. On many occasions, however, the positive action has been noted where the only clinical condition calling for attention was the presence of an attack of acute jaundice. So often does this occur that it has even been maintained that the Widal reaction is present as a rule in jaundice. This is not so, however, for many cases of jaundice occur without the reaction being present, and when jaundice is experimentally induced in animals, the reaction is always absent. Several cases of jaundice with

positive reaction have been investigated by Steinberg, in Germany, and by Libman, in America, and both come to the same conclusion that where this condition occurs, it is merely an atypical typhoid infection. It is held that the jaundice in such cases is of infectious origin, the organism being either the typhoid bacillus or some very closely allied organism. In several of Libman's cases, indeed, he was able to isolate the typhoid bacillus. If their view be correct, we are to look on what has been regarded as an exception to the principle of specificity of agglutinating reactions rather as an additional fact in its favour.

#### Noise and Sickness.

To sensitive natures there are few things harder to bear than a succession of unpleasant auditory stimuli. Under certain circumstances the healthy listener can hardly tolerate even harmonious sounds, much less discords against which his whole soul rebels. Men of less sensitive nerve centres cannot understand or appreciate the effects produced by noise of all kinds upon their more impressionable brethren whom they, therefore, consider fussy and irritable. It cannot be denied that there is a good deal of unnecessary noise heard in the streets and other public places of large cities. The shouts of newsvendors, the shrieking of locomotive-engines, the clanging of church bells, and the grinding of street organs are only a few of the unmelodious sounds that might be more or less considerably lessened. That modern disease of the nervous system, neurasthenia, owes no small part of its origin to the effects produced by noise upon the receptive organs and the higher nerve centres. The very existence of a society for the suppression or abolition of street noises is an indication that civilised humanity is beginning to cry out against some of the paralysing influences of modern life, so far as one of the special senses is concerned. Many acute diseases, especially those of the brain, are injuriously affected by noise, and patients are far more likely to do well if nursed by those who are gentle and quiet in their ways than by attendants of loud voice and blustering habits. Dr. J. A. Guthrie, of the United States Navy, has recently commented upon the great value of the "silent signal" in naval manoeuvres, the orders being obeyed with alacrity and without confusion. It is suggested that electrical methods might often be employed as a means of diminishing unnecessary noise.

#### Registration of Nurses

It is a curious fact that a nation like our own, which depends in a greater degree than any other on the product of its brains, should take so little interest in educational questions, and that the interest taken is mostly by way of hindering rather than of advancing the educational cause. This, too, when the other progressive nations of the world are spending more money on education every year. A striking commentary on this state of things is the attitude that most of the members

of the medical profession have taken up in their evidence before the Select Committee of the House of Commons, now sitting to inquire into the subject of the State Registration of Nurses. Dr. Norman Moore, of St. Bartholomew's Hospital, who has had fifteen years' experience of teaching and examining nurses, is of opinion that the qualities that make a good nurse are widely distributed among all classes of the community, and therefore that any steps which tend to raise the standard of preliminary education of nurses would be a mistake, as it would cut out a number who were otherwise fitted for the work. Compare this with what is taking place in America. In the Children's Hospital at Boston arrangements are being made with Simmons' College, a neighbouring women's technical school, by which all would-be probationers, before joining the hospital, are to pass through special courses in anatomy, physiology, chemistry, bacteriology, and sanitation for four months, so that the studies in these subjects may not be interfered with by ward work. After the four months have elapsed the candidates are to go into the Nursing Home for two months for instruction in domestic science, cooking, and the essentials of practical work in a hospital. At the end of this time they will be started on their three years' course of ordinary hospital training. With every regard for those qualities that make a nurse acceptable to sick people, it is impossible to overlook the fact that it is becoming more necessary every day for nurses to have an intelligent practical acquaintance with the work of their profession; and with plenty of candidates always coming forward, it ought not to be difficult to select those who are personally suitable. For our own part we are all in favour of raising the standard of their training and education, and of giving them such benefits as result from registration, both for their sake and that of the public.

#### Stagnin.

A NEW drug that will fill an important gap in pharmacology seems likely to be soon within the reach of physicians. This body was discovered accidentally by Landon, who was working on spleen-substance with a view to proving its usefulness in the treatment of anæmia. In the course of his studies he discovered that spleen-substance, or some body it contains, is possessed of great hæmostatic powers, and that, unlike adrenalin, it produces its effect, not by arterial contraction, but by markedly increasing the coagulability of the blood itself. It is now generally recognised that valuable as adrenalin is for external application, its use for internal hæmorrhage is frequently contra-indicated, as, side by side with the diminution of volume of the arterioles it causes increased general blood pressure, which tends to counteract the good done locally. With stagnin, as Landon has named his new product, this is not so, for it has no local effect on the arteries, and in conditions like menorrhagia and hæmoptysis, when the only chance of bringing

about hæmostasis is by acting on the blood itself, it promises to have a wide field of usefulness. Stagnin is prepared from the fresh spleens of horses by mixing the scraped pulp with salt solution and a little chloroform and alkali. After extraction for twenty-four or fifty-eight hours at 37° C., the mixture is filtered; the filtrate is then evaporated and precipitated with alcohol. A dry powder is eventually obtained which dissolves readily in water to form a clear, yellow fluid. Stagnin has been given by the mouth and by hypodermic injection, but its most marked effects have been produced by the latter method. With the range of organo-therapy developing as it is, we seem likely to be soon in possession of a number of most valuable additions to our armamentarium.

#### The Dustman, Old and New.

IN spite of the excellent way in which, on the whole, the Public Health Acts are administered, there are many weak places which are sufficiently obvious even to the man in the street. The methods adopted for the collection and removal of house refuse, for instance, are often primitive as those of the Far East. In a certain set of lantern slides which are, we believe, still exhibited sometimes by health lecturers, there is an amusing picture of a public official who, in strange garb and bearing a disreputable-looking basket, is dignified by the name of "A London Dustman." Such a spectacle is surely a relic of past times, when sanitation was in its infancy, and it is to be hoped that official has changed greatly since this particular slide was prepared. Nevertheless, there is still much to be desired in the manner in which dust and other refuse is collected. The days of the old brick dust-bins are, happily, ended, at least so far as the metropolis is concerned, and neater and more compact galvanised iron receptacles provided with tightly-fitting lids have supplanted them almost entirely. The householder's premises are now no longer soiled by droppings of ashes or vegetable *débris* from the dustman's basket during his weekly or bi-weekly visits, as was formerly the case, but, on the other hand, we still note the nuisance of spilt dust when bins are emptied in the dust-cart. The latter is frequently a source of much annoyance, especially in windy weather. The better collection of dust was the subject of much discussion at the recent Conference of the London Sanitary Authorities, held at the County Hall, Spring Gardens. One of the best ways of removal of house refuse would be for the full bin to be taken away entirely unopened, and a clean empty one left in its place. The cart bearing the full bins could then proceed directly to a central station, where their contents could be appropriately dealt with.

#### Athletics and Health.

ONE of the commonest comments made by the public in reference to the domination of athletics over the youth of these countries and of America, is that a devotion to athletics is, as a rule, detri-

mental to longevity. The great physical strain undergone, say, in a boat-race or a hard-fought sprint, is said to conduce to heart disease or heart weakness, and wiseacres are always ready to back up their opinion by a reference to "poor So-and-So," who, though the best oar of his time, died before thirty. Those, however, who have taken the trouble to investigate for themselves the after-history of athletes of note have usually come to a contrary opinion. In England an exhaustive inquiry into the health of past members of the 'Varsity crews has shown that their lives are, in an insurance sense, "good" much beyond the average. In the United States more recently Dr. Meylan, of the Columbia Gymnasium, has examined the lives of one hundred and fifty-two oarsmen who had rowed for Harvard in the forty years 1852-1892. He was led to the task by the statement of an old rower that all the other men who had pulled in his boat had died young—a statement proved, on careful inquiry, to be entirely fanciful. Of the 152 oarsmen, 123 are still living, and have most of them been interviewed by Dr. Meylan. Of those who died, six were killed in the Civil War, one in a railway accident, and one in a carriage accident—causes hardly to be traced to the ill effects of athleticism. Of those who died of disease, heart disease accounted for two, pneumonia for three, apoplexy for two, paresis (?) for two, cancer for one, phthisis for one, Bright's disease for two, alcoholism for one, while the causes in the other cases were not to be ascertained. Certainly from such a list it would be hard to trace any direct relation to athletics. An interesting point incidentally discovered by Dr. Meylan is that of the survivors not one has made a failure in life, and most of them have reached the class that was so frequently demonstrated to Martin Chuzzlewit, "the most remarkable men in the country."

#### Heart Massage.

THERE are few things in modern surgery which appeal more to the lay mind, which delights in sensations, than the comparative fearlessness which now marks our attitude toward the heart. Time was, not so many years ago, when any wound of the heart was regarded as necessarily fatal, and when surgical manipulation of that organ would have been regarded as an act of bravado beyond the range of the most ambitious operator. At present, however, suture of the heart has been practised successfully so many times that it is regarded as the direct duty of the surgeon in cases of heart-wound. Manipulation of the heart in another condition has recently presented itself as a legitimate procedure, and calls for general attention. It has been found that in cases of heart failure through collapse, and consequent apparent death, the heart may again be excited to contract by grasping it in the hand and performing rhythmic contractions. This has been performed successfully in some cases, and, as the patient was all but dead at the moment it was undertaken, no question of added risk in opening

the thorax need arise. Particularly when collapse occurs during the course of a severe abdominal operation, if other measures for restoring cardiac activity fail, and if the heart cannot be grasped through the diaphragm, it would appear to be the duty of the surgeon to incise that membrane, and perform rhythmic contractions of the heart. It is possible, too, that in cases of apparent death from drowning, heart massage may succeed where other measures fail. This is certainly the case with lower animals, as Professor Richet, of Paris, is in the habit of demonstrating in the case of dogs. It is likely, indeed, that the ordinary movements made in performing artificial respiration act, not only on the lungs, but also, by pressure on the heart walls, as a mechanical irritant to the heart itself.

#### A New Disease.

DR. BYROM BRAMWELL recently brought to the notice of the profession a curious case of infantilism, which he believes to be due to the absence or atrophy of the pancreas, or, at any rate, the absence of the pancreatic secretion. When first seen two years ago, the patient, a lad of eighteen, did not appear to be more than eleven years of age. He was well proportioned, bright, and intelligent, but had not grown during the previous seven years. He suffered from chronic diarrhoea for many years; the urine was free from sugar. Several tests were employed which demonstrated that no pancreatic juice reached the intestine. Dr. Bramwell immediately started treatment with pancreatic extract, and the result seems to support his diagnosis. The diarrhoea has ceased, and the bodily development is very marked, the patient having increased five and a half inches in height, and a stone and a half in weight. The sexual organs, which two years ago were infantile, are now developing normally, and the voice has become masculine. Dr. Bramwell thinks that the condition has not hitherto been recognised, and suggests that where it has occurred it has probably been mistaken for sporadic cretinism, though the points of difference are obvious enough.

#### Nurses' Slander Action.

AN action was heard at Londonderry on July 21st, in which eight nurses employed in the Derry Workhouse Hospital sought to recover damages for defamatory words stated to have been used by a female guardian, Mrs. Morris. This person, since her election to the Board a few years ago, appears to have made herself, in the words of her own counsel, "a holy terror" to all connected with the workhouse—guardians, doctors, and nurses. The slander complained of consisted of speaking of the nurses as "brazen-faced strumpets" and "lying tinkers," "a bad lot," and stating that whereas they had formerly "decent nurses" in the hospital, they had none now. Though denying that the words had the defamatory sense attributed to them, the defendant admitted that she had spoken of some of her fellow-guardians as "rotten Catholics." A verdict was brought in for the plaintiffs, with assessment of

damages at one shilling in each case for each plaintiff. It is hard to see what principle guided the jury in fixing the damages at a trivial sum, unless they thought that the words of such a person as Mrs. Morris were not likely to carry sufficient weight to injure the plaintiffs to any substantial degree. At the same time it is unfair that the nurses have to pay heavy costs for the protection of their characters.

#### Intestinal Diverticula.

It is only within the last few years that acquired diverticula of the intestine have come to be regarded as anything more than pathological curiosities. Recent observations, however, show that they are much more common than were formerly supposed, and in the bowels of old people they are probably very common indeed. They occur both in the small and large intestine, most commonly in the latter, and vary considerably in position and size. In the small intestine, the diverticulum usually, but not always, penetrates between the two layers of the mesentery, while in the large, the commonest site is immediately beside one of the longitudinal muscle-bundles. In size, they are rarely larger than a walnut, and most often nearer the size of a large pea, while they are commonly multiple. While there has been a good deal of controversy, and some inconclusive experimentation, as to the producing cause of the diverticula, they are probably due to the pressure of contained feces acting at points of diminished muscular strength. That pressure is really the active cause seems to be shown by the fact that in some cases the diverticulum is merely a protrusion of the mucous through the muscular coat of the gut, while in others all the coats take part in its formation. It is obvious that a diverticulum of the intestine may give rise to pathological conditions of very various nature, of great importance, and of difficult diagnosis. Since the wall of the diverticulum is thinner than the normal wall of the gut, it is, of course, easy for inflammatory conditions to spread to the peritoneum, and many such cases have been recorded. Dr. Edwin Beer, of New York, who has made an exhaustive examination (a) of the literature of the subject, emphasises the frequency with which such inflammations have been mistaken for malignant disease, the error occurring even on the operating table. Among the other complications he has noted are stenosis of the gut, perforation into the peritoneum, abscess, and fistula leading into the bladder.

#### PERSONAL.

THE Marquis of Ripon, as Chancellor of the University of Leeds, will inaugurate the first full session of that body at the forthcoming graduation ceremony on October 6th.

THE proceedings of the National Temperance League

(a) *Amer. Journ. Med. Sci.*, July, 1904.

at Oxford promise this year to be of unusual interest. The annual Association meeting breakfast on the 28th will be presided over by Mr. McAdam Eccles.

GOLF-PLAYING members of the medical profession at the Oxford meeting should note the address of Dr. Proudfoot, 43 St. Giles, Oxford, who has charge of the golfing arrangements. There is an excellent course about four miles from the city.

PRINCIPAL LANG presided at the recent meeting of the University Court, which discussed the formal proposals for the quarter-centenary celebration of the University of Aberdeen, which will occur in 1906.

It was practically agreed by the Aberdeen Court to defer the proposed installation of Lord Strathcona and Mount Royal until the year following that of the quarter-centenary.

DR. BURGEN, of Montreal, has been elected President of the American Medico-Psychological Society, said to be the oldest medical society in America.

DR. BURT, of Ontario, has been elected President for 1905 of the Ontario Medical Association.

LORD STRATHCONA has presented 20,000 dollars to the University of Manitoba, the sum to be expended on the Science Department of the University.

We offer our congratulations to Dr. Kendal Franks on the honour of knighthood conferred on him last week by the King. He formerly occupied a leading position in Dublin medical circles, and was Surgeon-in-Ordinary to the Viceroy of Ireland. Ill-health, however, caused him to resign his various appointments, and to seek the more congenial climate of the Cape. During the South African War he was appointed Consulting Surgeon to His Majesty's Forces.

THE Home Secretary has appointed Mr. Clinton Thomas Dent, F.R.C.S., to the post of Chief Surgeon to the Metropolitan Police, rendered vacant by the death of Mr. A. O. McKellar.

THE Empress-Dowager of China has presented ten thousand taels towards the new Medical College and Hospital now building in Peking.

ON the occasion of the recent visit of the Bristol Health Department to Dartmouth, an interesting presentation was made to Dr. D. S. Davies, the well known and popular Medical Officer of Health of the first-mentioned town. The presentation took the form of a handsome silver salver.

### Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

#### SCOTLAND.

*Care of Imbecile Children.*—The Medical Committee of the Edinburgh Parish Council are considering the advisability of providing a home at the new Bangor Asylum for the imbecile children of the city. At present those who have to deal with these most melancholy cases are too well aware of the great difficulty of inducing the parochial authorities to do anything for them—and this is not unnatural, for, unless the parents are in a position to pay a very considerable sum towards their support, the cost to the parish in maintaining them in such institutions as Larbert is very great. Added to this is the fact that accommodation for imbeciles at the lowest scale of charges, which is all that the parochial authorities can pay, is very limited, and practically it results that the majority of imbeciles in the parish must remain at home, a trial to their families and deprived of even the slight prospect of improvement which suitable institutional treatment

affords. It is much to be hoped that the Parish Council will make some provision for these patients, and thus relieve the parents of one of the cruellest burdens which can afflict the poor.

*Graduation Ceremonial at Edinburgh University.*—The University Session was definitely brought to an end on Saturday by the usual autumn graduation ceremony in the McEwan Hall. The honorary degree of LL.D. was conferred on Emeritus Professor Butcher, who so recently resigned the chair of Greek in this university, on Sir Walter Hely-Hutchinson, Mr. John Morley, M.P., Sir George Reid, ex-president of the Royal Scottish Academy, and Professor William Thompson, Registrar of the Cape University. Thereafter the ordinary degrees in medicine and science were granted, and the prizes distributed. The graduates were then addressed by Professor Cunningham, the text of his remarks being the evolution of the graduation ceremonial. The office of Promoter for the year (as the professor who introduces the graduates is called) is one of great antiquity, going back, as it does, to the earliest period of university life. The symbolic part of the ceremony is a survival of earlier times, but represents only a small part of the imposing display which accompanied the conferring of degrees in the Middle Ages. In those days preparations were made for days before the ceremony took place, and on the day of the ceremony a general holiday was observed. Rector, Promoter, masters, doctors, and masters in arts, all with their insignia, took part in a solemn procession to the cathedral, accompanied by the noise of drums and trumpets. In the majority of universities not more than one candidate was publicly promoted to the degree of master or doctor in the year, the heavy cost rendering graduation for these degrees somewhat rare occurrences. In only a few of the modern European universities has much of the old graduation ritual been preserved; in France there is practically no ceremonial; in Germany too, it has been abandoned. The ancient ritual is retained more or less intact in the Papal University of Rome, as also in Spain; and in Coimbra (Portugal) the ceremonial survives in its purest form. Little or nothing of the old ceremonial survives in Oxford or Cambridge. In former days the new graduate, among other ceremonies, had to receive the kiss of peace not only from the Promoter and the Chancellor, but also from the other doctors and masters present. Lady graduates of to-day will heave a sigh of relief to learn that only a small part of the ancient customs now survive in Edinburgh. The velvet cap placed on the head of candidates is the principal surviving characteristic; it is the sign of liberty, and originally meant the emancipation of the new doctor from the thralldom and subjection of the pupillary period.

*Edinburgh Simpson Memorial Maternity Hospital.*—The directors have appointed Dr. Lamond Lackie and Dr. H. Oliphant Nicholson to be Assistant Physicians to that institution. Both gentlemen are well known in Edinburgh and their appointments are cordially welcomed.

## British Medical Association.

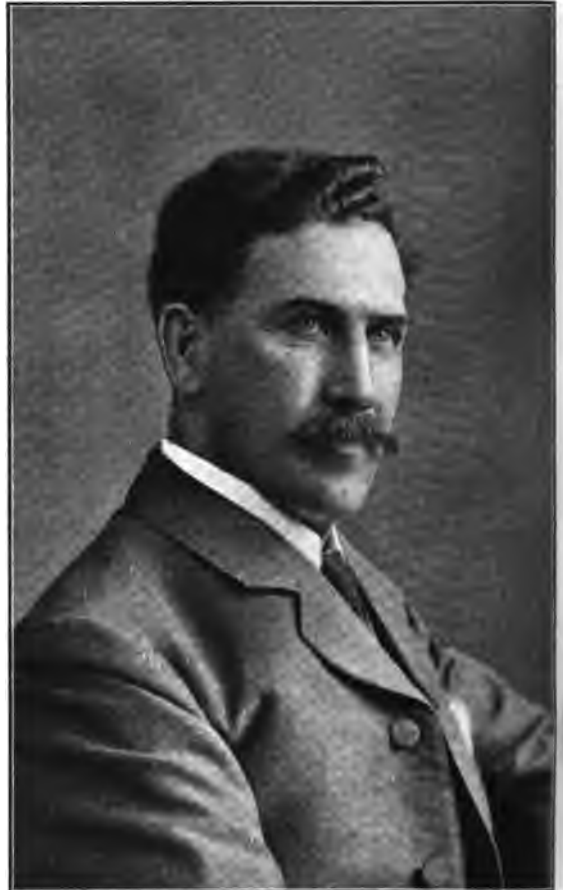
[BY OUR SPECIAL MEDICAL REPORTER.]

THE SEVENTY-SECOND ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION IS BEING HELD THIS WEEK AT OXFORD, FROM TUESDAY TO FRIDAY, JULY 26TH TO 29TH.

It is peculiarly fitting that representatives of British medicine should congregate in one of our most ancient seats of learning, rich in its inheritance from out the long-storied past. Oxford has done much for the advancement of physic, and not a few practitioners of the healing art have brought distinction and renown to their Alma Mater. The University may well be proud of its association with medicine. Its graduates from the twelfth century till now have been eminent in their profession, and many benefactions have come to the city through the life and work of her physicians.

Oxford will do well to keep in mind the names of her illustrious medicals. The many visitors to Oxford will find inexhaustible stores of delight in its ancient colleges and peaceful pleasaunces; its ever attractive river and glorious countryside; and when it is remembered that extensive preparations have been made for an open-handed hospitality it may well be that the purely scientific work of the meeting will be maintained chiefly by the enthusiasts and progressives of the Association.

### THE NEW PRESIDENT.



DR. WILLIAM COLLIER is well fitted, both by personal characteristics and professional position, to fill worthily the Presidential Chair of the British Medical Association.

Dr. Collier was educated at Sherborne and Jesus College, Cambridge, and proceeded to his M.A. in 1881. As an athletic blue he competed in the Inter-University sports in "the mile" and the "three mile" during three seasons of 1875-78. In the latter year he entered King's College Hospital, and took his M.R.C.S. and L.S.A. in 1880. In 1881 he graduated M.B. of Cambridge, and in 1885 took his M.D.

He is well acquainted with the details of hospital work, having held resident appointments at Addenbrooke's Hospital, Cambridge, Wolverhampton General Hospital, and the Radcliffe Infirmary, Oxford. In 1885 he was elected Hon. Physician to the latter.

In 1886 he took the Membership of the College of Physicians and in 1892 was elected a Fellow.

Dr. Collier is also an M.A. of Oxford. He is now Litchfield Clinical Lecturer, and holds other important positions. He is also a member of various learned societies, and has contributed several important articles to medical literature, the best known of which deal with problems connected with cardiac affections.

Dr. Collier occupies a unique position as head of the great body of associated medical practitioners in Great Britain, and may be trusted to sustain the dignity



and to extend the influence of the Presidentship of the British Medical Association.

#### RELIGIOUS SERVICES.

Remembering the close association of divinity and physic in our schools, and religion and the healing art in daily life, it is peculiarly fitting that religious services should mark the annual gathering of medical practitioners. On Tuesday morning, services were held in Christ Church Cathedral and St. Aloysius Catholic Church. This morning services are being conducted in Mansfield College Chapel and at Manchester College.

#### GENERAL ARRANGEMENTS AND REPRESENTATIVE MEETINGS.

The organisers have been at much pains to arrange everything for the comfort and convenience of the visitors. The reception room is in the Examination Schools in the High Street, where also the general and representative meetings are to be held. The general addresses are to be delivered in the Sheldonian Theatre. The sections will conduct their work in the various departments of the University Museum, with the exception of the Sections of Ophthalmology and Dental Surgery, which will be held in Keble College. The "doings" of the day are conveniently defined in the "Daily Journal." The stranger will find much of interest in the excellent handbook to Oxford.

The address of the President, Dr. William Collier, was given last evening before a large and representative audience. The reception of distinguished guests was a feature of much interest. The adoption of academic costume on this and other occasions does much to brighten the festive scene, and it is thought that mere male millinery will not prove prejudicial to the scientific sense of the gatherings. Sir William Church gives the Address in Medicine this evening, and to-morrow afternoon Sir William MacEwen the Address in Surgery.

#### THE WORK OF THE SECTIONS.

Amidst the numerous attractions of the annual gathering it is particularly desirable that no pains should be spared to maintain the scientific work of the proceedings. This year, although no epoch-making discovery may be announced, or great departure in practice be initiated, it seems probable that a high level of excellence in the work of the fourteen sections may be attained. By a wise arrangement, special discussions have been announced, and in many instances abstracts of the introductory papers have appeared in the Association's official publication.

In the Section of Medicine, a consideration of the treatment of tuberculous pleural effusion and pneumothorax will be introduced by Professor W. Osler, of Baltimore. The serum treatment of disease and the management of chronic Bright's disease will also furnish much material for discussion.

Surgeons will be interested in the discussion on the present aspects of a sepsis and antiseptics; and the indications for, and methods of, performing hysterectomy should give rise to a free expression of opinion.

All the Sections have prepared attractive programmes of papers, many of which will doubtless do much to advance our knowledge of the subjects with which they deal. We hope to refer to the more important discussions and papers in our next issue, and we shall publish abstracts of some of the more important of the communications.

#### THE PATHOLOGICAL MUSEUM.

This year a praiseworthy attempt has been made to present as far as possible the results of recent investigations in medical science. The collection is arranged in the large, well-lighted, readily accessible ground-floor rooms of the Anatomical Department. We understand exhibitors are to be given an opportunity of personally demonstrating their specimens or apparatus at definite times. Among the more important exhibits are specimens of ankylostomiasis, miners' lung disease, diseases of tropical climates, and preparations illustrating congenital dislocation of the hip before and after treatment by Lorenz's method, the estimation of the phagocytic power of the blood, and the detection of purin bodies in the urine. General satisfaction is

given by the museum being kept entirely distinct from the trade exhibits.

#### THE EXHIBITION.

A collection of medical, surgical, dietetic, and sanitary apparatus, medical books, and hospital appliances has been brought together in the Examination School, in the same building as the reception room. Much difference of opinion exists as to the wisdom of providing for a trade exhibit under the auspices of the Association, but while much can doubtless be said in favour of discounting such an alliance on the grounds of expediency, reasons can be adduced for its retention. Most of the leading medical publishers have, however, abstained from exhibiting.

#### ENTERTAINMENTS AND EXCURSIONS.

While the scientific work of the Association must ever be accorded first place, it is well that the more festive features of the week should not be allowed to lapse, and this has evidently been the opinion of the Oxford Committee, who have prepared a very attractive programme of entertainments and excursions. The annual dinner will be held in Christ Church Hall on Thursday evening. On Thursday afternoon an international golf match is to take place.

#### SPECIAL MEETINGS.

The annual assembly is wisely made an opportunity for holding other meetings at which matters intimately concerned with medicine or pertaining to the work of medical practitioners may be discussed. This year several important gatherings have been arranged for. The annual medical temperance breakfast is to be held in the Town Hall on Thursday morning, presided over by Mr. McAdam Eccles, who will be supported by the President, Sir William Broadbent, Sir Thomas Barlow, Sir Victor Horsley, and other leaders of the profession. The forty-fifth annual meeting of the New Sydenham Society is to be held on Friday, July 29th, at 9.30 a.m. The annual luncheon of the Continental-Anglo-American Medical Society is to be held at the Clarendon Hotel on Thursday, at 1 p.m.

## Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My two critics to some extent answer each other. My thanks are due to Dr. Drysdale for dealing with the first part of Dr. Walsh's paper.

If the chief advocates or apologists of "prevention," as well as its chief opponents, are both agreed that the diminishing birth-rate is due mainly (in the words of Dr. Billings) to "the deliberate and voluntary prevention of child-bearing on the part of a steadily increasing number of married people, who not only prefer to have few children but know how to attain that wish," we need not trouble ourselves much either with technical errors of classification or with a long and wordy discussion on subsidiary causes recognised as such by myself as well as by my critics. Dr. Walsh may be technically right in the method employed by him for computing the birth-rate, but with all his ingenuity he cannot turn a "minus" into a "plus," and in using it he falls into a far greater fallacy than any he thinks he is exposing. For we have increasing evidence that the habit of "prevention" is not, as I hoped, confined to married life and prostitution, but is becoming more and more used by the unmarried, and this, rather than any moral improvement, may account, and probably does account, for much of the decrease in illegitimate births. This practically disposes of the first twelve of Dr. Walsh's so-called conclusions.

Dr. Walsh's later conclusions cover more debatable ground, containing, as they do, references to one of the most important points of the controversy—*viz.*, the quality as well as the quantity of the children born to the nation. This I have dealt with as far as I could, not by assumption but by records of fact. The only possible



justification for the following of so unnatural a practice as that of sexual congress habitually adjusted to a certainty of imperfection would lie in a great benefit accruing to posterity, or, in other words, in the greater value of the population after being subject to such restriction. This "greater value" is now shown to be non-existent. There may be diversity of opinion as to how this result is produced, but there can be little question of the fact. Instead of a greater value we find a lessening value—a deterioration in quality as well as a limitation in quantity—and I search in vain in the writings of my critics for anything but vague questionings to disprove what I have advanced regarding this decadency.

Most of my critics, and especially Mr. Wells and Dr. Walsh, take a far too narrow and imperfect view of evolution. They appear to assume that the process is one of continuous advance for all nations and times. They lose sight of the ebb as well as the flow of progress. They seem to forget the records of history, the vast periods of national decadence and slow destruction, on which and through which we have slowly climbed to our present position. They have not adequately recognised the moral basis on which national greatness rests. And it is small comfort, I submit, to the twentieth century Englishman to know that the human may still develop in power and energy if such development must rest on the ruins of the Empire which his fathers made. The late Dr. Engelmann of Boston, wrote as follows, in 1903, (a) and I agree with him:—

"The factors are the same which have been active in earlier civilisations as they are to-day. Increasing wealth and the introduction of foreign manners are pointed out as causing in ancient Rome the lessening fertility among the better classes which preceded political disruption. Cause and effect were the same, and even the methods employed to thwart the tendencies of Nature were the same:—

"Sed jacet aurato vix ulla puerpera lecto

Tantum artes hujus, tantum medicamina possunt,  
Quæ steriles facit, atque homines in ventre necandos  
Conducit."

(Juvenal: Sat. vi., 594-7.) (b)

Both of my critics bring forward the old fallacy that there is no room in the United Kingdom for a larger population. There may be no room for the drugged neurotic, the lunatic, and the youthful criminal—the very classes we are increasing in some way by "prevention"; there is always room for the healthy-minded, the pure, the worker, and the brave. At what period, I would like to ask, were the old-world cities of Tyre and Sidon too small for the Phœnicians, who had founded their prosperity? Was it not at the time of their greatest power and influence when the Phœnicians were sweeping the Mediterranean with their commerce and establishing their colonies in Asia Minor, in Cyprus, in Greece, in Africa, in Crete, in Sardinia, in Spain, and even in England?

If the United Kingdom is too small, the British Empire is not. Large continents with inexhaustible lands under our protection or influence are crying out for capable colonists, not for the two children of the "prevented" family, who will never be fit to leave their mother's leading-strings, but for such men and women as made the Empire from Elizabeth to Victoria, men and women who are manœuvred out of existence by the wickedness of to-day.

Dr. Walsh suggests that the cause and effects of the diminishing birth-rate may be best ascertained by a Royal Commission of Inquiry.

Does he not know that a Royal Commission was appointed by the New South Wales Government in August, 1903, to consider and report upon the serious decline in the birth-rate, and that their report, published one month after my address, bears out in a striking

degree every word that I have said on this subject? I take the following from the *Australasian Medical Gazette*, of March 21st, 1904:—

"We consider the report (of the Royal Commission) a masterpiece of exhaustive examination and investigation of a subject which, it is admitted on all hands, bristles with difficulties. The Commissioners have found as a result of their investigations that the decline of the birth-rate is due in very large measure, not to any physical degeneration or lack of fertility in the present generation of Australian women, but to deliberate checking of the procreation of children by various artificial methods, thus nullifying one of the main objects of marriage and degrading the married state from one of honour to that of "monogynous prostitution."

The Commissioners are also most emphatic in their conclusions that the adoption of these practices for the limitation of families tends to the physical and moral degeneration of the race. They point out that the increase of insanity is going *pari passu* with the decline in the birth-rate; and there can be no doubt that a very large amount of ovarian and uterine disease is to be attributed to the use of various instruments which are used to prevent conception, but which favour sepsis and thus predispose to chronic disease of the uterus and its annexa."

Dr. Walsh has appealed to a Royal Commission; to this Royal Commission I refer him, asking him to note that through the whole of my indictment I have striven to be fair and sympathetic, and that nowhere in my writing will he find any expression so deliberately offensive as this of "monogynous prostitution."

But I have something more to say, Sir, to Dr. Walsh and to others of the profession who are rightly interested in this important subject. The evil exposed by the Royal Commission is not now confined to married life. It is spreading, as I have already pointed out, to the young and single, and the statistics of illegitimate births have no longer any necessary definite bearing on morality. Why should the bond of marriage, the new generation is asking, be the necessary precursor to sexual life when there need be no danger of pregnancy?

My tongue is tied by the confessions of my patients, but I do not care to be the deposit of shameful secrets without publicly entering my protest and declaring my belief that the so-called civilisation which spreads the knowledge of "artifices for making women sterile" in almost every house and practically encourages the living lie of a secret immorality in the unmarried sisters and daughters of our country is decadent and corrupt. Unless it can be cleansed and purified it cannot last, and deserves to be swept away as other civilisations have gone down before it.

But is it too late to alter?

I am, Sir, yours truly,

JOHN W. TAYLOR.

22 Newhall Street, Birmingham, July 22nd, 1904.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—Dr. Walsh seems to dispute the statement that the diminishing birth-rate can be due to the artificial sterility of married couples. The effect of this cause is, however, recognised by his equals in scientific authority. I have before me the English version of the recently published great work by Professor Metchnikoff, of the Pasteur Institute, "The Nature of Man," edited by Dr. P. Chalmers Mitchell. In an introduction the editor writes: "Metchnikoff is an expert of experts in the science of life, and has gained the right to a hearing by forty years of patient devotion and brilliant research." At page 101, Metchnikoff writes: "To the human race belongs the distinction of having invented modes of sexual congress which are necessarily barren. . . . There are many ways in which the spermatozoa may be prevented from accomplishing their function, and these are so common and so familiar that it is unnecessary to enumerate them. In civilised countries procreation is limited chiefly by such means."

(a) "Cause of Race Decline." *Popular Science Monthly*

(b) TRALS.—"Few children are born in the gilded bed to the wealthy dame, so many artifices has she, and so many drugs to render women sterile and destroy life within the womb."

After discussing the practice of artificial abortion and infanticide among primitive races, the author (page 105) remarks: "In more highly civilised nations, the rude proceedings of savages have been replaced by clever devices to prevent conception, and infanticide has become rare. Artificial abortion is excited by modern methods suggested by the progress of science. The embryonic membranes are pierced not by ribs of seals or hairpins, but by sterilised sounds, and the operation is performed with strict asepsis. In averting the natural results of passion the woman is subjected to the smallest possible risk. It is indubitable that more than one race has perished because of its lack of the instinct of family. . . . It is plain that the readiness with which devices to prevent the production of children have been adopted shows the weakness of the family instinct in man, and opens up a problem to which the attention of moralists and legislators may well be directed."

It is necessary only to read French works on social problems and fiction, and to mingle in French society of different classes, to learn at first hand the fact as to the almost universal practice among married couples of limiting the offspring to a number previously agreed upon. No secret is made of this custom, nor is any shame ascribed to it. It is discussed freely in family council by parents and betrothed couples, although delicate details may not be entered into before an ingenuous maiden. This fact is very well brought out in a recently published little book which, although composed in lighter vein, deserves and has received praise from serious reviewers. The book in question is styled "My French Friends." It is written by a lady who shows a complete knowledge of French life and social customs. The question of limiting the number of children is referred to over and over again in conversation on the subject of marriage, and no doubt is left as to the custom which prevails. French parents would consider it barbarous and cruel to bring into the world a number of children whose future they could not provide for. The provision of a suitable *dot* for the girl is the first consideration. As one of the characters, a model French mother as well as an intellectual woman of the world, remarks: "Happily the problem of six or ten children in the family which can only provide suitably for two or three, is not one we often give ourselves to solve here in France, but in all cases the future of the girl is regarded as of equal importance with that of the son."

The application of these ideas saves boys in great part from the fight in life without which fine manly character can rarely be attained, and makes of the girl a wife and mother, however ill-suited she be for this *rôle*.

I venture to affirm that not a particle of scientific evidence has ever been adduced to prove that progressive civilisation leads to the evolution of an infertile type. On the other hand, the evidence is overwhelming that the stagnation of population in France, allowing for the effects of late marriages and large preventable infantile mortality, is due mainly to the artificial prevention of conception practised by the great bulk of married couples.

On numerous occasions when you have allowed me to enter into the discussion of this subject, I have given the reasons for the belief that a nation which becomes imbued with the form of narrow egoism which constitutes the foundation of the custom almost universal in France, is doomed to gradual decay and destruction; and I need not repeat those reasons now. Finally, I believe that the diminishing birth-rate in this country is very largely due to the adoption in late years of French ideas and practices, and that the resulting ill-effects upon the moral fibre of large sections of the people are already discernible to close observation.

I am, Sir, yours truly,  
A STUDENT OF SOCIOLOGY.

#### SOME OF THE NEWER METHODS OF OPENING AND CLOSING THE ABDOMEN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—The plan of closing skin wounds in the abdo-

minal wall, which Dr. Hastings Tweedy describes in your last issue and appears to consider "so far as he knows, is novel," is in reality nothing more or less than an adaptation of Nathaniel Bozeman's well-known "button suture," formed of leaden discs, which proved so successful in his hands nearly a quarter of a century ago in the treatment of vesico-vaginal fistulæ!

Dr. Tweedy states that the suture he uses is left in "for fourteen days," and then cut. I am under the impression that cutting would hardly be required if silk-worm-gut sutures were left so long imbedded in the tissues; perhaps he may mean that part of suture tied over leaden plate. Dr. Nathan Bozeman, the designer of this form of suture, from whom I hold a letter on the subject, also considered the leaden plate had some influence on the healing; I should imagine by its equable pressure, and by preventing movement of the parts and cutting also. The idea of a perforated leaden plate as a splint for the cut surface is not novel, but, as we would say nowadays, ancient history.

I am, Sir, yours truly,  
ALEXANDER DUKE.

#### OUR "DAILIES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is probable that some of us, when looking through one of the "dailies" and finding the report of some medical conference or society, cannot help thinking how different it was years ago, when such subjects would have been thought proper only in one of our own journals. Science is now fashionable, and it is natural that those who are interested in social questions, into which medical science enters more or less forcibly, should read with attention the report of a discussion upon any subject that has relation to the wide and important one of public health. Health and wealth are so closely associated that we cannot afford to neglect the one without loss of the other. When matters medical are introduced to the public through our "dailies," or other non-professional journals, it is necessary to make some allowance for the difficulties of giving those who have no knowledge of medical science correct and clear ideas of the questions discussed, and of the conclusions at which well-educated members of the profession arrive when dealing with some new theory or discovery, particularly when such is subversive of the views or doctrines they have held and believed in before. We hope now to consider somewhat carefully the work that is being carried on by the society engaged in the research into the origin, nature, and treatment of cancer. This disease is one of those that can be traced back to almost prehistoric times, and it seems as if the difficulties of solving the question of its origin are now greater than ever. We are deeply impressed with the importance of looking more to the prevention than to the cure of cancer, particularly when we see how this is necessary in the interests of public health. No class, of course, takes precedence of infectious diseases, or at least none that requires more carefully to be considered by our Legislature. As cancer does not belong to this class it is probable that its treatment will be of far greater interest than research into its origin, and we must be careful lest we indulge too much in hopes that may be held out to us by those who are clever enough to take advantage of poor humanity.

In the report of one of our leading "dailies" of the third meeting of the General Committee of the Cancer Research Fund, it is stated that: "The public and the medical profession are, therefore, gravely warned not to delay to take advantage of the surgeon's aid in the hope that some means will speedily be found to replace surgical interference." If any non-professional understands this we must say we should feel some surprise, for how anyone could fly to the surgeon in the hope that that is the best way to do without him is difficult to understand. The public and the profession are both treated as innocent and ignorant questionists of the nature and treatment of cancer. "The report contained one weighty warning. No sign has yet been

discovered by which the physician or surgeon may surely recognise the presence of cancer." Some of our readers may agree with this opinion, and some may not. We are rather inclined to think that no one is more likely to be correct in the diagnosis of cancer than the physician or surgeon who has given up his life to the clinical study of disease. It is not likely that those who have done nothing but work with the microscope and in the laboratory can have any idea of the kind of knowledge obtained by clinical study; and if the Cancer Research Society is going to assume a superiority over the profession and warn it and the public through the "dailies" in the tone of the report from which the above extracts were made, we think it well in the interests of the public first, and next in that of clinical medicine and new students, to warn them, the public and the profession, against the warnings of a society that works in such an illogical and unscientific spirit. As far as we can make out there is nothing left now, according to the report of the Cancer Research Fund, but for the poor public to rush off to the surgeons to operate for fear of cancer, and to be kept in most painful suspense till the end of life is near and the difficulties of diagnosis are settled.

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

#### CENTRAL MIDWIVES' BOARD AGAIN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your excellent leader on the Midwives' Board's "sheer stupidity and egregious performances" appeals to every sensible member of the profession. The attempted levelling down of the doctors to the position of man-midwife seems like going back a century. No wonder you pertinently ask, "Whence have the nursing profession of the day obtained this knowledge in training, except from the hands of medical men?" some of whom apparently have for years made a "good thing" out of it; and perhaps the knowledge of this fact impels some such to the further exaltation of the midwife and the depreciation of the medical man. Is it likely the midwife, recognising her power, will play second fiddle to the most experienced practitioner, unless compelled by risk of losing her patient, to ask his help? Dr. Ward Cousins deserves thanks for voicing the profession, "who feel strongly on the point," and the matter cannot be allowed to rest, nor Dr. Cullingworth's eminence save him from censure by thus lowering his own profession.

I am, Sir, yours truly,

A. D.

#### Obituary.

ARTHUR K. CROSSFIELD, L.R.C.S., L.R.C.P.ED., J.P., DARTMOUTH.

MR. ARTHUR KYFFIN CROSSFIELD died recently at his residence, Dartmouth, after a short illness, from appendicitis. The deceased, who was in his fifty-second year, was the son of the late Mr. R. Crossfield, of Douglas, Isle of Man. He was educated in Edinburgh, and took the qualifications of L.R.C.P., L.R.C.S., L.M. Edin., in 1878. After holding a resident appointment at the Isle of Man, he commenced practice at Dartmouth. He took great interest in the volunteer movement, was surgeon-lieutenant-colonel in the 2nd Devon Royal Garrison Artillery Volunteers. Mr. Crossfield was a Justice of the Peace for the borough of Clifton-Dartmouth-Hardness. His loss will be felt among a wide circle of friends.

SIR JOHN SIMON, K.C.B., M.D. DUB., F.R.S. F.R.C.S., LL.D., OXON. LL.D. CANTAB.

We regret to announce the death of Sir John Simon, K.C.B., on Saturday, the 23rd inst., at his residence in Kensington. Born in 1816, he became an Honorary Fellow of the Royal College of Surgeons in 1844, and was the first appointed Officer of Health to the City of London in 1848. For many years he acted as Surgeon to St. Thomas's Hospital. From 1855 to 1876 he was Medical Officer to the Board of Health, to the Privy Council, and to the Local Government Board. He was the author of several papers on physiology, pathology,

and surgery, and of reports and other official papers relating to the sanitary state of the people of England. The University of Munich, at its 400th anniversary, in 1872, conferred upon him the honorary diploma of Doctor of Medicine. So far as his scientific work was concerned, he may be regarded as one of the great pioneers in State medicine, and the series of official Reports issued under his presidency are models of classical style and valuable records of original investigation. He was made a C.B. in 1876 and a K.C.B. in 1887, and was one of the Crown members of the General Medical Council. In 1878 he was elected President of the Royal College of Surgeons, and in 1879 of the Royal Society.

#### Literature.

##### HYDROTHERAPY. (a)

THE speedy appearance of a second edition affords the surest proof that the first issue has been approved, and certainly in the present case Dr. Baruch's excellent treatise on the therapeutic and hygienic uses of water well merits the appreciation it has received. The new edition has been thoroughly revised and brought up-to-date, and much new matter has been added. The work still retains its former aspect. The principles of hydrotherapy are first discussed, and then follow details regarding methods and particulars concerning application in special diseases. In the new edition a chapter on reaction affords much valuable material as to the physiological basis of hydrotherapy. A chapter on insanity has also been added, and in it the wisdom of a rational application of water as an alleviating agent is clearly indicated.

The work is written in a judicial and scientific spirit, although full of the energy of the enthusiast. The author is anxious to place the practice of hydrotherapy on a sound and rational basis, and we venture to think his effort should go far to divorce it from the slipshod, inexact, and quackish procedures which only too widely prevail in so-called hydropathic establishments.

Dr. Baruch may be congratulated on having produced a book which has found favour in all English-speaking countries, and which is likely to influence beneficially hydrotherapeutic practice in both America and Europe.

##### NOBLE SMITH ON LATERAL CURVATURE. (b)

THIS is a short but practical treatise on the treatment of what usually proves to be a very intractable condition. The author points out that in the treatment of spinal curvature the real cause of the deformity is inefficient nutrition of the various structures of the body. This results in softening of the bones so that lateral curvature is produced. He describes a number of exercises with a view to correcting the abnormal curves, and especially to overcome spinal rotation which is usually present in these cases. With regard to massage, the author states that it must not be applied indiscriminately, and that in the majority of cases it is quite unnecessary. He then goes on to describe the use of a special splint which he claims is of great value in the treatment of lateral curvature. It has the effect of supporting the patient's back, and yet allowing of perfect freedom of muscular movement.

The second portion of the book deals with the management of stooping, round shoulders, and kyphosis. The effects of clothing in the production of these conditions are clearly pointed out. Regarding the much-talked-of corset, he says that there is no great harm in its use so long as it leaves the thorax free from pressure. A series of very simple exercises for the correction of stooping is given, and the special splint already referred to is once more recommended. The

(a) "The Principles and Practice of Hydrotherapy. a Guide to the Application of Water in Disease. For Students and Practitioners of Medicine." By Simon Baruch, M.D., Professor of Hydrotherapeutics in the New York Post-Graduate Medical School and Hospital, &c. Second Edition, revised and enlarged. Pp. 496 and 74 figs. Price 76s. net. London: Bailliere, Tindall and Cox, 1904.

(b) "The Management of Lateral Curvature of the Spine, Stooping and the Development of the Chest in Phthisis." By E. Noble Smith, F.R.C.S. Edin., &c., Senior Surgeon to the City Orthopaedic Hospital, London. Pp. viii., 133. Price 2s. 6d. London: Smith Elder and Co. 1904.

book concludes with two suggestive chapters on the influence of diet upon physical development, and on the development of the chest in respiratory affections.

The author writes in a spirit of hopefulness regarding the lines of treatment advocated, and certainly his suggestions are worthy of careful trial. We can heartily commend this short treatise to those interested in the physical development of children. It is undoubtedly a valuable contribution to the literature of this important subject.

#### ROLLESTON'S CLINICAL LECTURES AND ESSAYS. (a)

THIS is a collection of seventeen lectures and papers on a variety of medical subjects, which have been reprinted with certain additions from the various journals in which they originally appeared. The opening lecture on "Vomiting in Diphtheria" is most instructive, as is also that on the "Treatment of Typhoid Fever." We are glad to renew our acquaintance with the case of persistent hereditary oedema which the author brought to the notice of the profession a short time ago. The account given of the case of Recklinghausen's disease is extremely interesting, as is also the description of the necropsy which the author was fortunate to obtain. The paper, entitled "Some Remarks on the Uses and Abuses of Arsenic" is full of valuable information, and will well repay careful study.

Taken as a whole, the topics dealt with in this volume are of interest to the general practitioner, while those who delight in the anomalies of clinical medicine will find within its pages much to ponder over. We think Dr. Rolleston is to be congratulated on having such a rich store of clinical material at his disposal, and on his extremely facile language in describing the conditions referred to in this collection.

#### MANN ON THE PHYSIOLOGY AND PATHOLOGY OF THE URINE. (b)

IN this excellent, though short work, the author endeavours to place before his reader the latest survey of those branches of biological chemistry which are connected with the physiology and pathology of the urine. Though the book is primarily intended as a clinical guide and chief prominence is given to methods of examination which can be carried out in the clinical laboratory, many other processes which are beyond the scope of a clinical laboratory are also described in order to prove of help to investigators "who desire to carry their researches further."

The book is most systematic in its arrangement. Commencing with a description of the general characteristics of urine, it next discusses the different urinary inorganic and organic constituents, the amido and aromatic acids, carbohydrates, proteids and nitrogenous substances, pigments, and bile acids. The special characteristics of urine are then discussed, as well as urinary sediments, and calculi, the volume ending with a section devoted to the study of urine in its pathological relations. The book is well and clearly written, and we can cordially recommend it to any one who possesses a fair knowledge of medical chemistry, and who is desirous of entering more fully into the special branch of the physiology and pathology of the urine.

#### THE NEW SYDENHAM SOCIETY ATLAS OF ILLUSTRATIONS. (c)

THE new Fasciculus of this beautiful Atlas deals with

(a) "Clinical Lectures and Essays on Abdominal and other Subjects." By H. D. Rolleston, M.A., M.D., Cantab., F.R.C.P., Physician to St. George's Hospital, &c. Pp. 178. Price 5s. net. London: Sidney Appleton, 1904.

(b) "Physiology and Pathology of the Urine with Methods of Examination." By J. Dixon Mann, M.D., F.R.C.P., Physician to the Salford Royal Hospital, Professor of Forensic Medicine in the Victoria University of Manchester. London: Charles Griffin and Co. Pp. xi. and 272, and several illustrations. 1904.

(c) "An Atlas of Illustrations of Clinical Medicine, Surgery, and Pathology, compiled for the New Sydenham Society." Fasciculus XVIII (Double Fasciculus), being VII and IX of the Clinical Atlas. Eruptions, &c., caused by Arsenic, Urticaria Pigmentosa, Illustrations of the Phenomena of Leprosy. London: The New Sydenham Society. Agent, H. K. Lewis, 1903.

three subjects—arsenical poisoning, urticaria pigmentosa, and leprosy. The fasciculus is a double one and contains a large number of original plates, including seven reproduced from photographs taken during the epidemic of poisoning by arsenic in Manchester in 1901. There are some especially good chromo-lithographs of the rare condition, urticaria pigmentosa. Each article is prefaced by very full introductory remarks on the different subjects by the Editor, and altogether the present number is well up to the standard that has been set by its predecessors.

#### ST. BARTHOLOMEW'S HOSPITAL REPORTS. (a)

IN the space at our disposal, we can do no more than direct the reader's attention to the wealth of information this Report contains. The volume opens with an In Memoriam notice, W. J. Walsham, which tells of the combination of genius and industry with an unfortunately delicate health. The writer tells the story with the sympathy and love of one who was both a pupil and a friend. The special features of the number are, however, the article of Dr. J. Graham Forbes, "Medical Report of the Anglo-French Boundary Commission on the Western Frontier of the Gold Coast Colony," which occupies eighteen pages and is beautifully illustrated with photographs. This is followed by a second article by the same author, "Native Methods of Treatment in West Africa," and Dr. Weber's paper "Action and Reaction in Pathology and Therapeutics." Turning to the ever-interesting statistics of anaesthetics, we find that chloroform alone was administered 2,847 times, ether alone 181 times. There were seven casualties, of which detailed accounts are given. We regret that we cannot give space to quotations of some length from Dr. Forbes' article on native treatment. We must, however, refer to the Rotunda, or, as some will say, Crédé's, method of pressing out the placenta, which has been practised for centuries on the Gold Coast. "The placenta is expressed immediately after the birth of the child," and a little further on we read that "Turning by abdominal palpation and moulding is practised when the child lies 'across the belly' to make the head or foot come first, either of which means of delivery is considered equally good." Aseptic precautions appear to be the rule, for the author says "No attempt for any reason is made to introduce the fingers into the vagina."

#### STEVENSON'S WOUNDS IN WAR. (b)

THE second edition of this excellent book will be welcome to all interested in military surgery. It is full of original and accurate information, and since the appearance of the first edition in 1897, the author has been able to draw from the rich store of experiences accumulated in the Boer War and those recorded in the statistics of the Spanish-American War. The systematic and detailed description of the various injuries due to projectiles and to hand-weapons involves a great amount of special information, just as the treatment of that class of wounds on the field demands a practical acquaintance with the conditions of campaigning. The civil surgeon will find this book full of interesting and suggestive material. The grazing of arteries, for instance, by bullets of high velocity gave rise to many of the "varicose aneurysms and aneurysmal varices that have been a remarkable feature of the surgery of the Boer War." In that campaign, again, it was for a short time supposed that the men were using poisoned bullets. A newspaper scare at the time was silenced only by the discovery that the supposed poison was nothing more than verdigris from the paraffin used for lubricating the copper cartridge cases. Many of the illustrations are new and illuminating. The skiagrams are for the most part excellent specimens taken in the Boer war. In wounds of the hip-joint General

(a) "Saint Bartholomew's Hospital Reports." Edited by A. E. Garrod, M.D., and Mr. McAdam Eccles, M.S., F.R.C.S. Vol. XXXIX. London: Smith, Elder and Co. 1904.

(b) "Wounds in War." By Surgeon-General W. F. Stevenson, C.B., A.M.S., Professor of Military Surgery, Netley, &c. Second Edition. London: Longmans, Green and Co. Price 15s. 1904.

Stevenson very properly insists upon the importance of accurate diagnosis at the earliest possible moment. This is in accordance with the teaching of modern scientific surgery, and is happily now brought within reach of the army surgeon by means of his Röntgen-ray equipment. The value of the present edition is considerably enhanced by a clear description of localisation by Mackenzie Davidson, undoubtedly the greatest living authority upon that subject. It is impossible to do justice to General Stevenson's book within the limits of a short notice, but it may be cordially recommended to readers interested in surgery as a classical and valuable work.

#### DEGENERATES. (a)

MANY startling statements are met with in this pamphlet by Dr. Rentoul. A remedy he suggests for checking the spread of lunacy is, that would-be suicides should be allowed to take their own lives without interference from the law. He also holds that "at present we are engaged in the apparently pleasant pastime of manufacturing lunatics and others of this class," and asks whether many of our philanthropic and other charitable societies do not work indirectly for the survival of the unfit. He also points out how Nature would reduce the number of lunatics to the smallest proportions were she not persistently and deliberately thwarted, and appears to deplore that we do all in our power to prevent suicide, by building palatial residences and appointing immense staffs to protect lunatics from their mental impulses. He thinks it fortunate that although thousands of pounds are expended yearly upon the care of lunatics, Nature's method—that of suicide—goes on and not only so, but increases. Nature, he states, will not forgive us for endeavouring to prevent lunatics and other degenerates from committing suicide.

"In the eight years, 1895-1903, 8,933 lunatics were discharged as recovered from the asylums under the London County Council, but of this number 2,285 were re-admitted within one year," and he asks, "Is it right and just to others that so large a proportion of recovered persons should be permitted to return to ordinary life there to beget a tainted offspring?" and we heartily agree with Dr. Rentoul that this is a most serious problem, because they cannot be kept in asylums after they become sane, and females are often discharged from an asylum recovered, to return within twelve months suffering from insanity of pregnancy or the puerperium.

The treatment he suggests is the sterilisation of mental and physical degenerates, and doubtless by some such treatment much could be done to decrease mental and physical degeneracy, although, even in this our day, we fear this line of treatment will be received by many with much disfavour.

Apart from the startling statements already quoted, there is much in this pamphlet which makes it worthy the perusal of medical men.

### Medical News.

#### Central Midwives' Board.—The Number of Examinations.

At an adjourned meeting of the Central Midwives Board, held at the offices on the 14th inst., the consideration of the examination scheme drafted by Dr. Cullingworth was continued. The question of the number of examinations to be held in a year was then raised, and its reconsideration was moved by Dr. Cullingworth, seconded by Miss Paget, and carried. Dr. Sinclair moved a resolution that the examinations should not take place more often than twice a year; he objected to the policy of "providing facilities for failures" to come up again, but no second was forthcoming. Dr. Cullingworth said that since the last meeting he had received representations from institutions engaged in the training of midwives showing if examinations were held only twice a year very great inconvenience would be felt by the schools, involving

difficulties in management which would militate against the efficiency of the training. He considered the reasons given so conclusive that he had altered his opinion. After some further discussion, in the course of which Dr. Champneys expressed the opinion that the training would be better if pupils were turned out more frequently in small batches, Dr. Sinclair begged the Board to think of "highly-trained nurses," not of "charwomen." A resolution in favour of examinations being held four times a year simultaneously in London and the provincial centres was moved by Dr. Cullingworth, seconded by Miss Paget, and carried, Dr. Champneys and Miss Oldham also voting for it. The final consideration of the scheme was deferred until October. The following institutions for the training of midwives under section C of the rules were approved: The Belfast Union Workhouse, the County and City of Cork Lying-in Hospital. Miss Paget gave notice of a resolution she wished to bring up at the next meeting, that midwives should be required to renew their licence annually. Mr. Ward Cousins asked leave to postpone a motion limiting appointment as inspectors under the Board to members of the medical profession.

#### Westminster Hospital Medical School.

THE annual distribution of prizes to the students of this school took place on the 15th inst. Colonel Sir Frederic Cardew, K.C.M.G., late Governor of Sierra Leone, who presided, after presenting the prizes spoke to the students of some of the problems that they might help to solve in their future career, especially that regarding the physical health of the people and its bearing on the manning of the army and navy. The teaching and experience of the medical profession must, he said, be one of the greatest determining factors in its solution. In the course of his address, Sir Frederic also touched on the great opening for medical men in the development of the various parts of the Empire, especially in the Tropics. The Army Medical Corps, however, now offered an attractive career to the medical practitioner and had the advantage of a pension during old age. Dr. Allchin, senior physician to the hospital, having proposed a vote of thanks to Sir Frederic Cardew, which was carried by acclamation, prizes were presented to the following gentlemen:—G. R. Ward, scholarship of 110 guineas and Treasurer's prize; H. Austin Smith, scholarship of £60; A. Davies, scholarship of £60; R. Brown, scholarship of £40 and prizes for medicine and surgery; C. F. Dawson-Smith, scholarship of £30; H. Hingston, scholarship of £60; R. Asplen, scholarship of £40; G. F. Carr, prizes for practical chemistry, physics and biology; E. G. Foote, prize for practical chemistry; L. White, midwifery prize; J. J. W. Evans, histology prize; C. Fletcher, pharmacology prize; R. S. Dollard, the Sturges prize for clinical medicine and the forensic medicine prize; and G. G. James, prizes for anatomy and physiology.

#### London School of Tropical Medicine.

Of the thirty-nine students who attended the above school during the Session, May to July, 1904, the following (all of the Colonial service), have passed the examination at the end of the course with distinction: J. Currie, A. King, E. Maples, P. N. Gerrard, C. A. Suvoong.

#### The Barker Anatomical Prize.

THIS prize of thirty guineas, offered annually and open to all students in any medical school in the United Kingdom, has just been awarded to Mr. Charles Cooper, a student of the Royal College of Surgeons, Ireland. This is the fifth year in succession that this open prize has been conferred on students of the Dublin College.

#### Trinity College, Dublin.

At the examinations during Trinity Term, 1904, Mr. John S. Joly won the Surgical Travelling Prize, and Mr. James G. Wallis the FitzPatrick Scholarship. The following gained medical scholarships:—In anatomy and institutes of medicine: Thomas O. Graham (Trinity College) and Francis O'B. Ellison (Stewart). In physics, chemistry, botany, and zoology, the following: Allman J. Powell (Trinity College) and George F. Graham (Stewart).

(a) "The Proposed Sterilisation of Certain Mental and Physical Degenerates." By Robert Reid Rentoul, M.D. The Walter Scott Publishing Co., Limited.

The Purser Medal was awarded to Mr. Francis R. Coppinger.

**Royal College of Physicians and Surgeons.**

THE following candidates have passed the Second Professional Examination:—

With Honours.—D. Adams, V. Clifford, J. D'Alton, P. G. M. Elvery, J. B. Hanafin, P. M. Keane, C. Sheahan, T. Sheehy, G. F. Shepherd.

Passed in all Subjects.—P. Blake, H. C. Carden, W. Carroll, N. E. Cussen, D. J. Hanafin, F. M. Hewson, E. Montgomery, J. B. M'Glancy, D. O'Sullivan.

Completed Examination.—R. J. Bonis, L. L. Davys, M. R. J. Hayes, J. Humphreys, W. St. L. Moorhead, F. J. Morris, D. T. O'Flynn.

**University of Aberdeen.**

At the graduation ceremony on Wednesday last, the following degrees were conferred:—

*Degree of M.D.*—Middleton Connon, M.B., C.M., James Cran, M.B., C.M., Ernest King Gawn, M.B., C.M., Henry Gibbons, M.B., C.M., Peter Harper, M.A., M.B., C.M., †David Albert Hutcheson, M.B., Ch.B., \*Arthur Hugh Lister, B.A., M.B., C.M., \*Hugh MacLean, M.B., Ch.B., John Smith Purdy, M.B., C.M., †Arthur Westerman, M.B., Ch.B., †George Nicol Wilson, M.B., C.M. \* "Highest Honours" for Thesis. † "Honours" for Thesis. ‡ "Commendation" for Thesis.

*Degrees of M.B. and Ch.B.*—Cyril Moore Smith, with second-class honours. (Passed Final Examination "with Distinction.") *Ordinary Degrees.*—Catherine Emslie Anderson, John Anderson, Wm. Robert Catto, William G. Gunn, Alexander A. Hendry, Thomas Christie Innes, Henry Williams Jeans, John Jenkins, M.A., Frederick Leonard Keith, Helen M'Glashan, Roderick Mackay, M.A., James Reid, M.A., Michael B. H. Ritchie, Fife Slater, James Hutcheon Thomson, Robert J. B. Wright.

The John Murray Medal and Scholarship was awarded to James Clark, M.B., Ch.B., and the Alexander Anderson Scholarship to Bertie R. G. Russell, M.B., Ch.B.

*Diploma in Public Health.*—Hugh Johnston, M.B., Ch.B., William Mackie, M.A., M.B., C.M.

**University of Glasgow.**

THE following have passed the fourth (final) professional examination:—

(A.)—For M.B., C.M.—Stewart Dunbar, Ernest Milton Watkins.

(B.)—For M.B., Ch.B.—Bethia Shanks Alexander, Archibald Craig Amy, Henry Græme Anderson, James Richard Sunner Anderson, Robert Daniels Bell, M.A.; David Blackley, Forrest Brechin, Charles Brown, George Yuille Caldwell, Roberta Campbell, Thomas Murdoch Campbell, M.A.; Peter Carrick, M.A.; Robert Buchanan Carslaw, M.A.; James Alexander Cowie, B.A. B.Sc.; Thomas Thornton Macklin Dishington, Charles Milligan Drew, M.A.; Hugh Harvey Fulton, John Graham, B.Sc.; George Munna Gray, John Cochrane Henderson, James Rutherford Kerr, John Kerr, Ethel MacLeod Lochhead, Peter Lowe, M.A., B.Sc.; Thomas Symington Macanlay, John Duncan M'Callum, M.A.; Donald Carmichael M'Cormick, Neil M'Dougall, James Boston M'Ewan, Tom Duncan M'Ewan, Duncan Macfayden, John M'Farlane, Alexander Stuart Murray Macgregor, James M'Houl, Ronald Mackinnon, Andrew Brown M'Pherson, James Roy M'Vail, James Marshall, Andrew Meek, Margaret Walker Millar, David Robertson Mitchell, John Muir, John Murdoch, Alexander Harper Napier, George Clement Nielson, Thomas Orr, Charlotte Reid Park, Howard Henderson Patrick, Jon Clegg Pickup, Andrew McLean Pollock, James Porter, William Murdoch Rae, William Rankin, M.A.; Donald Ronald Reid, Berkeley Hope Robertson, M.A., B.Sc.; Lawrence Drew Shaw, George Golde Smith, B.Sc., Jessie Marie Stewart, William Craig Stewart, Murray Ross Taylor, William Templeton, James White Thomson, William Young Turner, M.A.; Hugh Fleming Warwick; Robert M'Nair Wilson, Annie May Yates, Hugh Young.

The following candidates passed with distinction in the subjects indicated:—

In (a) Surgery and Clinical surgery, (b) Practice of Medicine and Clinical Medicine.—Thomas Orr. In (a) Practice of Medicine and Clinical Medicine, (b) Midwifery—Robert Buchanan Carslaw, M.A. In Surgery and Clinical Surgery—Margaret Hardy, Arthur Innes, Ethel MacLeod Lochhead, John Duncan M'Callum, M.A. George Goldie Smith, B.Sc.; Robert M'Nair Wilson. In Practice of Medicine and Clinical Medicine—Robert Daniels Bell, M.A.; David Blackley, Hugh Harvey Fulton, Tom Duncan M'Ewan, John Murdoch, Andrew Maclean Pollock, William Rankin, M.A.; Donald Ronald Reid, William Templeton, William Young Turner, M.A. In Midwifery—Forrest Brechin, Peter Carrick, M.A.; Louis Leisler Greig, Margaret Walker Millar, David Robertson Mitchell, Howard Henderson Patrick, David Penman, William Craig Stewart, John Unsworth.

**Conjoint Examination Board in Ireland.**

THE following candidates have passed the first Professional Examination by the Royal College of Physicians and the Royal College of Surgeons:—

(a) *Honours*—T. C. Boyd, T. P. Cormack, J. C. L. Day, C. Hyland, G. Patton, W.G. Ridgway, A. Sheridan, H. W. White.

(b) *In all subjects.*—G. E. Beggs, G. Collins, J. J. Cuskelly, G. A. Finegan, J. A. J. Flannery, M. J. Hawkshaw, F. N. Holden, D. J. Hurley, H. W. Kay, W. J. P. Lillis, D. J. Lyne, T. J. Lyons, J. McHugh, J. T. McKee, P. Maguire, J. P. Morgan, T. N. Neale, E. Ryan, M. J. Saunders, H. B. Sherlock, J. M. Smyth, C. H. Stringer, W. C. Townsend.

(c) *Completed Examination.*—S. W. Hudson, T. J. McDonnell.

**Royal College of Physicians and Surgeons and Faculty of Physicians and Surgeons, Glasgow.**

At the quarterly examination of the Conjoint Board, held in Edinburgh, and concluded on July 22nd, the following candidates passed the Final Examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. & S.E.:—Charles Henry Thomas, Canada; William Herbert Boalth, Kampti, India; Broderick Edward Middleton Newland, Bangalore; Bernard Beaumont Westlake, Chippenham; Eyre Vincen; Smith, Kingston, Jamaica; Bertram Ingram, Victoria; James Watson, Edinburgh; Arthur George Thompson, Ontario; Franklin Christian Richards, South Dakota; Frederick Etherington, Ontario; Edward Rainsford Mumford, Norwich; Charles Richard Whittaker, Lancashire; Charles Grange McGreer, Ontario; Annjuta Kellgren Cyriax, London; Daniel Michael Donovan, Cork; James Grieve Cormack, Anstruther; William Boyd, Co. Derry; Lambert Kenneth Rodriguez, Travancore; Eileen Josephine FitzGerald, Melbourne; Henry Gordon Campbell, Dundee; Dwarkanath Dharmaji Kamat, Bombay; Alexander Douglas Fox, Brighton; Ramchandra Kashinath Dhuru, Bombay, Nigel Oliphant, St. Andrews; David Arnold Hastings, Ireland; Vasantio Dinanath Madgavkar, Bombay; Narindra Singh Sedhi, Punjab; Sorabji Jamasji Bhatena, Bombay; William Vincent Saint John Sutton, Cork; and Joseph Simon de Souza, Bombay; and five passed in Medicine and Therapeutics, nine in Midwifery, and five in Medical Jurisprudence. Fifteen other candidates passed the First Examination, eighteen passed the second Examination, and sixteen passed the Third Examination at the recent meetings of the Board.

**Society of Apothecaries of London, July, 1904.**

THE following candidates having passing the necessary examinations, have received the L.S.A. diploma of the Society, entitling them to practise medicine, surgery, and midwifery:—L. F. Cope, C. Kellgren, and T. R. Waltenberg.

**Royal College of Surgeons in Ireland.**

*Fellowship Examination.*—Mr. C. W. H. Fleming, L.M. and S. Dublin University, having passed the necessary examination, has been admitted a Fellow of the College. Miss S. H. Commissariat, L.M. and S. Bombay University, has passed the primary part of the Fellowship examination.



## 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.

**BOLTONIENSIS.**—Pettenkofer's theory of the relation of ground water to enteric fever has never been accepted unreservedly by British authorities upon hygiene. It is, of course, possible that different local conditions have altered the case in Munich, where Pettenkofer made his observations. In that city the soil is porous, and the high ground water may have had exceptional opportunities of working mischief from the presence of an enormous number of leaking cess-pools. The point should, of course, always be borne in mind by the scientific sanitarian whatever his field of work.

### SURGERY AND SERMONS.

"I USED to give him advice about his operations, and he used to criticise my sermons. We watched his first performance of tracheotomy with the deepest interest, and I am sure his remarks helped me with my sermons." So spoke the Bishop of London last week concerning his early friendship with a hospital house surgeon, the occasion being prize day in connection with the Medical School at St. Bartholomew's Hospital.

**DR. H. T. S.**—It would be more satisfactory to both parties if you referred the question to an expert. There can be no arbitrary standard for the valuation, the value of practices varying according to circumstances. With regard to the other points, these are "cut and dried," and afford safeguards alike to the vendor and purchaser.

**MR. HARMAN.**—Your foreign diploma does not confer the right to practise in this country: that is to say, it does not convey the status of a registered medical practitioner. It is not for us to advise you how to evade the law, nor would you be wise to attempt it.

**DR. J. W. M.**—Your interesting case is marked for early insertion. **MR. CLEMENT SERES'** letter is unavoidably held over for want of pace: but enclosed communication has been read and posted to the gentleman concerned.

**DR. WATSON.**—A similar question was asked and replied to in our last week's issue under the signature of "A Subscriber," to which we would refer you.

**DR. K.** See reply to Dr. J. W. M.

## Vacancies.

- Ayr District Asylum.**—Junior Medical Officer.—Salary £120 per annum, with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.
- Carlisle Non-Provident Dispensary.**—Resident Medical Officer. Salary £150 per annum, with apartments (not board). Applications to the Honorary Secretary, Mr. G. A. Lightfoot, 23 Lowther Street, Carlisle.
- Stirling District Asylum, Larbert, N.B.**—Assistant Medical Officer. Salary £150 per annum, with board, &c. Applications to the Medical Superintendent.
- County Borough of South Shields.**—Medical Officer of Health. Salary £300 per annum. Applications to J. Moore Hayton, Town Clerk, Court Buildings, South Shields.
- Whitehaven and West Cumber and Infirmary.**—House Surgeon. Salary £150 per annum, with rooms and attendance. Applications to the Secretary.
- Brecon and Radnor Asylum, Talgarth, R.S.O.**—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, attendance, and laundry. Applications immediately to the Medical Superintendent.
- Rotherham Hospital and Dispensary.**—Senior House Surgeon. Salary £110 per annum, with rooms, commons, and washing. Applications to the Secretary, C. S. Baylis, 19 Moorgate Street, Rotherham.
- Leighton Buzzard Union.**—Medical Officer. Salary £260 per annum. Applications to Chas. W. B. Calcott, Solicitor, Leighton, Buzzard.
- Shillelagh Union.**—Medical Officer. Salary £120 per annum. Applications to J. Hopkins, Workhouse, Shillelagh, Co. Wicklow.
- House Surgeon, for a small Hospital in the Midlands.** Salary £100 per annum and board. Applications to Mr. P. W. Walker, 18 Waterloo Street, Birmingham.
- Southwark Union, London.**—Second Assistant Male Medical Officer at the Infirmary East/Dulwich Grove, S.E. Salary £100 per annum, with board, lodging, and washing. Applications to Howard

C. Jones, Clerk, Union Offices, John Street West, Blackfriars Road, S.E.

## Appointments.

- COLLINS, ETHELBERT, L.R.C.P.Lond., M.B.C.S.,** Coroner for the Bishop's Stortford District of East Hertfordshire.
- MUMFERRY, PERCY LOCKHART, B.C.Cantab., F.R.C.S.Eng.,** Assistant Surgeon to the North-Eastern Hospital for Children, Hackney Road.
- NEAL, F. C., M.R.C.S., L.R.C.P.,** Clinical Assistant to the Chelsea Hospital for Women, S.W.
- OARLEY, ADAM R. H., L.R.C.P., L.R.C.S.Edin.,** Third Honorary Anaesthetist to the London Throat Hospital, Great Portland Street.
- TURNER, F. D., M.B.Lond., M.R.C.S., L.R.O.P.,** Medical Officer to the Post Office and Medical Examiner to the Board of Education at Huddersfield.

## Births.

- BULLIED**—On July 17th, at The Old Vicarage, Midsomer, Norton-Somerset, the wife of Arthur Bullied, L.R.C.P., F.S.A., of a son.
- GUTCH**—On July 23rd, at 28 Ponnereau Road, Ipswich, the wife of John Gutch, M.D., B.C.Cantab., of a daughter.
- HAVELOCK**—On July 21st, at Sunnyside, Montrose, N.B., the wife of John G. Havelock, M.D., of a son.
- MANLOVE**—On July 21st, at 78 Warrior Square, St. Leonards-on-Sea, the wife of J. E. Manlove, L.R.C.P., M.R.C.T.J., of a son.
- YOUNG**—On July 21st, at 2 Palmeira Terrace, Hove, Sussex, to Dr. and Mrs. B. J. Erskine Young, a daughter (prematurely).

## Marriages.

- PERCIVAL-WARNER**—On July 21st at St. Peter's Church, Newcastle-on-Tyne, Archibald Stanley, M.A., M.B.Camb., youngest son of the late Stanley Percival, to Winifred Helen, youngest daughter of the late William Warner.
- THOMAS-ATKINSON**—On July 20th, at St. Mary's Church, Handsworth, Yorks, George Crewdson Thomas, M.D., M.R.C.P., of Sydenham, only son of George E. Thomas, of Swainswick, Bath, to Evelline Mary, elder daughter of William Atkinson, The Birklands, Handsworth.

## Deaths.

- MANN**—On May 18th, at Kisumu, British East Africa, Harold E. Mann, M.R.O.S., L.R.O.P., D.P.H., Medical Officer East Africa Protectorate, son of the late Major General Gother F. Mann, C.B., R.E., aged 39.
- SIMON**—On July 23rd, at 40 Kensington Square, London, in the 88th year of his age, Sir John Simon, K.C.B., M.D.Dub., M.R.C.S., F.R.S., formerly, Medical Officer of H.M. Privy Council, and Consulting Surgeon to St. Thomas's Hospital, London.

## OPERATIONS.—METROPOLITAN HOSPITALS.

- WEDNESDAY.**—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopaedic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street (9.30 a.m.), Gt. Northern Central (8.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- THURSDAY.**—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynaecological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- FRIDAY.**—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopaedic (2.30 p.m.), Soho Square (2 p.m.).
- SATURDAY.**—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (10 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- MONDAY.**—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynaecological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopaedic (2 p.m.), City Orthopaedic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).
- TUESDAY.**—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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## Original Communications.

### THE TREATMENT OF CHRONIC RENAL DISEASE. (a)

By W. HALE WHITE, M.D.Lond., F.R.C.P.,  
Physician, Guy's Hospital, London, &c., &c.

DR. HALE WHITE, in opening the discussion on the above subject, said that the exigencies of time compelled him to limit it to the treatment of the disease usually known as chronic Bright's disease. Many physicians have based their treatment largely upon the albuminuria, but this is wrong, for, probably, not much harm follows the mere loss of albumen in the urine, the amount so lost is always small and could be easily compensated for by a little more in the food, and, further, in many diseases such as cystitis, large amounts of albumen are lost in the urine, but no one thinks of directing the treatment directly against the albuminuria. The value of the albumen in the urine is that it enables us to diagnose the disease, and to estimate the progress it is making. It was pointed out that very often towards the end of a case, when the patient was at his worst, the amount of the albumen in the urine was less.

Passing to the cardio-vascular symptom, two conditions are met with. Some patients have a hypertrophied heart and high tension pulse, others are suffering from a weak, feeble heart. The first group must keep down their blood pressure, for they run considerable risk of fatal hæmorrhage, physical exercise should be gentle, the bowels should be loosely opened once a day to avoid strain at stool, meals should be small, alcohol should not be taken, and very little meat or soup or meat essences on account of the extractives in them. There should be no excessive drinking of fluids, and digitalis and other drugs which raise the blood pressure should not be given. Sometimes the weak, feeble heart met with in chronic Bright's disease is brought about by the fact that the patient has been starved; under the impression that most articles of food irritate the kidneys, he has been kept on nothing but milk. It is surprising how such patients are benefited by giving them a little meat and sometimes a little alcohol helps them. Often patients with Bright's disease are not allowed enough exercise, with the result that they become fat, and this is very bad for them because the already enlarged heart is not capable of conveying

the blood properly to the extra amount of fat tissue, hence the organ dilates.

Unless the heart has dilated, severe œdema is not a common symptom of chronic Bright's disease, although it is frequently met with in chronic tubal nephritis. It is best treated by posture. If it is in the legs they should be raised; if in the lungs, the patient should be turned from side to side. Diaphoretics do not often help much, but on the other hand the œdema subsides best when but little fluid is drunk. Still, the most efficient way to get rid of œdema is to puncture the legs with needles. The amount of fluid that will drain off is very great, and this relieves the œdema of other parts. Great care must be taken to see that the punctures in the legs are kept sweet, for the tissues of patients with Bright's disease are particularly liable to septic inflammation.

Many methods of treatment have been directed to avoiding substances which are supposed to be harmful because they irritate the kidneys. Certain drugs undoubtedly do this; for example, carbolic acid, cantharides, and turpentine. Other drugs are excreted with difficulty, such as mercury, lead, and digitalis. There is much difference of opinion about morphine. It certainly often benefits the convulsions of uræmia, but, inasmuch as the subjects of chronic Bright's disease are very easily poisoned by it, it should be very rarely used. We know really very little as to whether any articles of diet irritate the kidneys. Excessive drinking of alcohol is bad, but only 3 per cent. to 5 per cent. of alcohol, when only a moderate quantity is taken, is excreted by the kidneys. Therefore, a little alcohol does not irritate the kidneys at all. The guide in giving alcohol in Bright's disease is the pulse; if the tension is high it must not be given, if the tension is low it is often beneficial. As we are very ignorant as to the kind of food which irritates the kidneys, probably most patients with chronic Bright's disease are best if they take ordinary plain simple food in such quantity that their weight keeps about normal. There is no evidence that one form of meat is better than another, or that chicken and fish are better than beef and mutton, and most of the statements with regard to the dieting of patients with chronic Bright's disease are based upon entirely insufficient evidence. Often the patients are over-dieted, their food is unduly restricted, and they feel very much better when they are allowed more latitude. This is especially true of chronic tubal nephritis. Tea, coffee, and tobacco should all be used with great moderation by sufferers from chronic nephritis,

(a) Abstract of Paper read at the Oxford Meeting of the British Medical Association, July, 1904.

as we have already seen how important it is to keep the blood tension normal, and any of these three will render the pulse irregular, rapid, and of low tension. As a rule, too, much water drinking is bad, for if much is taken œdema will not subside, and excessive water drinking increases nitrogenous metabolism, and also a large amount of water raises the blood pressure.

There can be little doubt that uræmia is a form of poisoning. What the poison is we do not know. There is no evidence that it is derived from the food, for the onset of uræmia has not been shown to be associated with any particular article of diet, and large amounts of food in healthy persons do not lead to uræmia. Dr. Hale White quoted a case which was observed by himself and Dr. Spriggs, in which 5,000 kilocalories of food were taken a day for fifty-five days, at least 120 grammes of nitrogen were retained, but the patient had not uræmia. Further, there is no diminution in the output of nitrogen during uræmia. As there is no evidence that uræmia is connected with the food, it is supposed that the poison is produced within the body. As we know of no antidote to it nor of any way of stopping its formation, all we can do is to render the excretory channels of the body active. Therefore, the bowels should be kept open, the patient should be made to sweat, and any diarrhœa and vomiting should not be checked. Often benefit follows transfusion, probably because some of the poison is washed out; bleeding, too, is often beneficial. As this treatment is correct for uræmia, it is well for a patient with chronic Bright's disease always to keep the bowels well open, and to have a hot bath occasionally so as if possible to ward off uræmia. Inasmuch as in Egypt the heat is great and the humidity of the air is low, it is an ideal climate for sufferers from chronic Bright's disease, for they perspire quickly and the perspiration rapidly evaporates.

Dr. Hale White concluded by saying that he had confined himself strictly to points in the treatment of which he had had personal experience, and he left it for other speakers to give their views upon the treatments to which he had not alluded.

### OUR SANITARY NEEDS, WITH SPECIAL REFERENCE TO THE NATIONAL HEALTH. (a)

By SIR W. SELBY CHURCH, K.C.B., M.D.,  
Physician, St. Bartholomew's Hospital.

AFTER a brief reference to the condition of medical knowledge in 1868, when the Association last met in Oxford, it was pointed out that the meeting could almost be taken as marking the commencement of our present views concerning febrile and some other diseases, Lord Lister having the year before read at Dublin his paper on "The Antiseptic Principle in the Practice of Surgery," and the medical world just beginning to recognise the infectivity of tubercle. Allusion was made to Sir Wm. Gull's address in 1868 on "Medicine," and our present knowledge contrasted with his statement about infectious diseases, that they spread by emanations from the sick, but whether as amorphous material or as germs we know no more than a thousand years ago. The importance of our acquaintance with

the internal secretions of organs was touched upon, and disappointment expressed that expectations roused by the success of thyroid feeding in myxœdema had not as yet been fulfilled in the case of diseases of other organs.

After a short reference to the condition of medical practitioners in Greece and Rome, and the evolution of the profession in this country during mediæval times, the rise of sanitary legislation was considered, and the passing of the Medical Act of 1858 was taken as marking the advent of a new branch of medicine—Preventive or State Medicine. The need for codification and simplification in our sanitary procedure was pointed out, and the necessity for the Medical Department of the Local Government Board having more power and acting as an advisory as well as a supervising body. The need for a much closer supervision of the manufacture and sale of food-stuffs was considered, and the desirability of health authorities having greater powers than they at present possess in preventing the overcrowding of localities as well as houses.

The mistake of rural communities municipally adopting the principles of liquid sewage disposal, notwithstanding the difficulties that are known, was referred to, and the disadvantages attendant on the overgrown size of buildings in our towns was alluded to. The Registrar-General's returns were quoted as showing that the mortality increased with the denseness of the population, and that this was especially the case with infant mortality. In conclusion, the Association was urged to use its influence to spread the knowledge of sanitation, and to point out both to the public and the Government the desirability for a physical census of the nation being taken from time to time, and the necessity for the registration of the physical condition of the children in our primary and secondary schools being kept.

### THE SEASIDE CURE: ITS INDICATIONS AND CONTRA-INDICATIONS.

By ALFRED S. GUBB, M.D. (Paris). &c.,  
Of *Mustapha Supérieur*, Algiers, and *Aix-les-Bains*.

THE season for sea-bathing has returned, and practitioners in general will be asked to express an opinion on the advisability of going to the seaside for the restoration of health. It is by no means easy to formulate an opinion on the subject based on scientific principles, because the "sea-air cure" has not been methodically investigated. It has been empirically employed from time immemorial, but in truth more on the personal initiative of the patient than on the advice of physicians who have taken the trouble to think the matter out, and who can specify its indications and contra-indications. At the Thalasso-therapeutic Congress, held at Nice last year, a number of papers were read on the subject, some of them of considerable value since they were based on numerous observations which throw fresh light on an obscure subject.

We have first to ask ourselves, What is the action of the "sea-cure"? This comprises two divisions, viz., the action of sea-air, *i.e.*, the purely climatic aspect, and, secondly, the action of sea-baths. Now the properties of sea-air may be summarised as follows: The air at sea level attains its maximum density, and the barometric pressure is at its highest. Under these conditions the respiratory movements are reduced in number but increased in amplitude. It follows that the air circulates more freely in the respiratory tract, and that the circulation of blood in the lungs takes place more easily. Moreover, a given volume of sea-air contains a larger proportion of oxygen than inland or mountain air, and this determines an increase in the

(a) Abstract of the Address on Medicine given at Oxford, July 28th, 1904.

number of red corpuscles as well as an augmentation in the proportion of hæmoglobin. Then, too, sea-air is markedly freer from dust and consequently from ærial micro-organisms than land air, advantages upon which it is hardly necessary to insist. The prevailing temperature is more uniform, but, on the other hand, the winds are more frequent and stronger. Among their effects must be noted that they promote evaporation from the cutaneous surface and cause a loss of surface heat which stimulates organic exchange.

Light, which is such an important factor in a climate, is at its maximum at the sea-shore, and, light for light, it is richer in chemical and therapeutically active rays. It exerts a pronounced stimulating action on metabolism and produces a beneficial action on the vasomotor system, which Huchard describes as "the peripheral heart which, ramifying beneath the skin, regulates and governs the function of the central heart."

It is generally admitted that sea-air contains a larger proportion of ozone, and, along with this, a larger proportion of aqueous vapour. In districts immediately adjacent to the seaboard the air, especially in rough weather, becomes laden with fine spray, containing the alkaline chlorides, bromides, and iodides, though, according to Lalesque, the proportions of these salts present in sea-air has been much exaggerated. Gautier and Duphil, as a matter of fact, only found 22 and 15 thousandths of a milligramme per litre of sea-air.

It will be seen, then, that sea-air is made up of elements which, for the most part, are stimulants. It stimulates metabolism, at any rate in the sick, and for a limited period—until they have become acclimatised—in the healthy. Clinically it increases the appetite, and indirectly brings about an increase of body weight. The circulatory and respiratory functions are slowed, cutaneous perspiration and diuresis increase, the muscular strength is enhanced, and the proportion of red corpuscles in the blood is raised.

#### SEA-BATHING.

The action of sea-baths is markedly stimulating. They influence the respiratory and general exchanges, first of all by chilling the cutaneous surface, as in any application of cold hydrotherapeutics, and these effects are enhanced by the richness of the water in mineral constituents; lastly, the movements of the bather in swimming and the mobility of the water itself constitute a genuine massage of the whole body.

Albert Robin and Binet explain the action of sea-baths as follows: "The various elements of activity in a sea-bath stimulate the peripheral nerve terminals, and the extensive nervous surface of the integument, and this stimulus is transmitted centripetally to the nerve centres, which preside over general nutrition."

The action of the "sea-treatment" cannot be better summarised than in the words employed by Dr. Robin, in his address at the Congress just referred to: "Denser, of a more uniform temperature, rendered more salutary by the winds and the waves, saturated with salt iodised vapours, bathed in light, it stimulates all the vital functions—the appetite, digestion, assimilation, and the various chemical acts of elementary nutrition. Respiration finds therein purer and more stimulating elements, it regulates hæmatosis, and molecular regeneration." Sea-baths, moreover, accentuate the double process of assimilation and disassimilation which together constitute nutrition, this prime manifestation of vital energy. It promotes the combustion of the residues of organic activity which, instead of stagnating in the organism and by their retention engendering functional disturbances which are the forerunners of actual disease, are rendered soluble and their elimination from the economy thus facilitated. Sea-air and sea-bathing, these powerful modifying agents of intra-organic exchanges, are, therefore, a means of regeneration, of "reincorporation," as it was called by the ancients, who thought, reasonably enough, that by renovating the tissues they could modify inherited and acquired tendencies and wash away, so to speak, latent morbid predispositions inherent to particular organisms.

#### INDICATIONS AND CONTRA-INDICATIONS.

The reply to the question as to the special diseases

likely to derive benefit from the "sea-cure" is to be inferred from what we have just said, *i.e.*, all diseases characterised by a slowing down of nutrition. Whenever in a given patient we wish to accelerate general and respiratory exchanges, we should send him to the sea-side. Formulated in this general way the conclusion appears simple enough; but in practice the point is often difficult to decide and requires for its proper appreciation precise observation and numerous distinctions. Let us begin by asking ourselves what are exactly the modifications of nutrition, provided by sea stimulation. According to Robin and Binet the organic exchanges are accelerated *en bloc*, and the increased activity bears more particularly on nitrogenous metabolism. The excretion of mineral elements is reduced, the evolution of ternary substances is more satisfactory, the proportion of uric acid diminishes, the assimilation of alimentary phosphates is more perfect, the increase in the proportion of earthy phosphates to the phosphoric acid testifies to more active changes in the osseous and nervous systems; the solubility of the fluids for uric acid is enhanced, the assimilation of nitrogenous substances is markedly increased, and depends not upon greater organic combustion, but upon a better assimilation of these principles.

How, then are we to establish the nutritive budget of the patient? To do so not only takes time but requires a special laboratory and a chemical expert. Robin, however, holds that it is sufficient to weigh the patient regularly. The amount of albumen consumed per kilogram of body weight in the twenty-four hours is estimated by noting the elimination of chloride of sodium. If the consumption of albumen, thus measured, increases or even remains stationary, while at the same time the excretion of chloride of sodium diminishes, the patient should not remain at the sea-side. A further consideration has to be borne in mind that of the particular station to which the patient is to be sent. The seaside climate is not the same everywhere. We have discussed its fundamental qualities, but a host of factors associated with the topography of the place, its exposure to winds, its relative humidity, its vegetation, &c., modify its curative action. In a particular resort, well protected from north and west winds, near which there are pine forests, we shall obtain sedative effects, whereas in another resort, which is swept by the winds and is poor in vegetation, the effects will be purely stimulating. The neighbourhood of Algiers, for instance, shut in as it is by mountains; will always present a much higher hygrometric record than stations higher up the hills, which are better ventilated and retain less cloud and damp. Certain resorts may be divided into zones according to the distance from the sea-shore of its various districts, their exposure to wind, their aspect in regard to the sun, and their flora. The slopes of Mustapha Supérieur, above Algiers, will prove beneficial to many categories of patients who would derive anything but benefit from a sojourn to the west of Algiers at St. Eugene, for example.

In addition to the peculiarities of the particular station we must also study the peculiarities of the patient. The inadequacy of the nutritive processes may not be due to any slowing down thereof, but to excessive demands thereon. In such cases the seaside is unsuitable, for it would accentuate the overstrain. The stimulating effects of sea-air on the other hand, are not produced in every instance. Seaside practitioners meet with patients in whom metabolism is exaggerated, who nevertheless bear seaside residence very well and even improve. The stimulant effects are also modified by acclimatisation. Lastly, the different zones of a particular station may, as we have shown, possess different curative qualities if the treatment be modified accordingly.

Under these circumstances the seaside treatment may be advised in respect of the following categories of patients—anæmic patients with slowed nutrition, convalescents from febrile diseases, sufferers from malaria, patients of lymphatic temperament, the

strumous and in certain forms of neurasthenia with imperfect nutrition. The treatment is also suitable for rickety subjects, and in many osseous affections. Cases of chronic tuberculous adenitis with low nutrition will often be benefited by residence at the seaside.

The victims of pulmonary tuberculosis in whom the nutritive exchanges are usually over-active, are better at a distance from the sea, but there are exceptions to this rule, for in Algiers we are familiar with instances in which great and permanent benefit has followed residence near the sea in such cases. This question has given rise to much discussion, and although, as a general rule, we may admit with Robin that our object must be "to calm the tuberculous, to extinguish the fire that is consuming them and not blow it into a flame by the sea breeze," that does not prove that these patients will derive no benefit from the seaside. We have shown, indeed, that the topography of certain stations attenuates the stimulating effects.

According to Manquat the tuberculous may be classified in four categories—(a) torpid tuberculosis in persons whose nutritive exchanges are normal or sub-normal, whose circulation is calm, whose lesions are circumscribed and stationary; these may improve at the seaside; (b) those whose lesions evolve *per saltum*, i.e., acute outbreaks followed by periods of remission of variable duration. These should be sent to a sedative station and residence too near the sea must be prohibited; (c) cases of acute, rapidly-progressing tuberculosis should never be allowed near the sea; (d) the incurable cases, in which the choice of a climate is of less importance and may be left in great measure to individual taste.

Persons predisposed to pulmonary tuberculosis, whose nutritive changes are unduly active, should be kept at a distance from the sea. According to Robin, the great majority of the tuberculous derive no benefit from the seaside. The only exceptions to this rule are (1) the tuberculous whose respiratory exchanges are not in excess, i.e., about 8 per cent. of such cases; (2) the phthisical who, although their respiratory exchanges are in excess, eat, digest, and assimilate badly in such wise that the excess of oxygen which they consume hastens the consumption of their own tissues. In these a temporary stimulation of the digestive and assimilative functions will divert to the ingested food a portion of the surplus oxygen. The Mediterranean seaboard may, according to Huchard, be recommended to cardiac patients in winter on condition that they have not reached the period of asystole. The seaside, on the other hand, is contra-indicated in aneurysm and dilatation of the aorta, in coronary angina pectoris, in pseudo-angina pectoris of neuralgic origin, and in cardiac states associated with the phenomena of hyper-systole, or cardiac excitement with frequent attacks of palpitation.

Rheumatic subjects with acute or subacute attacks usually find their state to be aggravated by residence close to the sea, and the same may be said of arthritics subject to neuralgic attacks. Neuralgics and the so-called "herpetics," are oftener than not, worse near the sea, and moist climates in general are injurious to them.

Arthritics, whose nutrition is merely slowed; the subjects of arterio-sclerosis without grave complications; the obese by nutritional slowing down; and the gouty and hyposthenic dyspeptic, may derive marked benefit from the seaside. Certain phosphaturic neurasthenics also benefit therefrom, but the pure neurasthenic will, as a rule, do better in a sedative climate.

Lastly, hysterical subjects are often worse near the sea, or feel so, but they need not on that account be sent elsewhere. According to Mendelsohn these patients often complain of stimulating phenomena in no wise due to any modification of the special excitability of the sensory and motor nervous system. Their state is due rather to a psychical condition brought about by emotional hyper-sensitiveness. Should this psychical state not rapidly yield to acclimatisation or

"suggestion," it is preferable not to insist, but to advise removal from the neighbourhood of the sea.

#### INDICATIONS AND CONTRA-INDICATIONS OF SEABATHS.

Sea-baths are suitable for the rickety, the lymphatic, the strumous, the subjects of osseous and glandular tuberculosis, in anæmia with slowed nutrition, in obesity by defective metabolism, in those predisposed to gout, in chronic auto-intoxication, in hyposthenic dyspepsia, in convalescence after febrile diseases, and for diabetics when nutrition has begun to give way.

### THE PRINCIPLES OF OPEN-AIR TREATMENT OF TUBERCULOSIS.

By T. CARSON FISHER, M.D., &c.,  
Dunstone Park Sanatorium, Paignton, Devon.

In recent years much interest has been shown by the profession and the public in the "open-air" treatment of tuberculosis. It has been discussed in medical and lay papers, in crowded congresses, and it has now quite a literature of its own. In spite of this publicity there are vague and conflicting opinions regarding the scope, limitations, and results of "open-air" methods.

The writer having for many years treated consumption in various climates, both at home and abroad, having been for some years past Resident Physician in various home sanatoria, and having visited many others, endeavours in this article to give a brief summary of various practical points in open-air, hygienic, or sanatorium treatment of tuberculosis.

The former pessimism about consumption has passed away, and in its place there is risk of somewhat undue optimism. It is certain that, according to pathological and clinical research, the disease is spontaneously curable in a considerable percentage of cases.

Dr. Bulstrode, (a) in his Milroy Lectures, quotes an extract from one of Professor C. Allbutt's addresses: "I am guilty of no extravagance when I suggest that one-third of you who hear me, wittingly or unwittingly, are, or have been, affected with tubercle."

The human organism is refractory to the tubercle bacillus. Some are practically immune. Authors such as Flugge state that the cough spray-drop of the phthisical contains tubercle bacilli; yet doctors, students, nurses, and others inhale these daily with apparent immunity.

The power of resistance in most people is greater than was imagined, or the virulence of the toxins has altered as in other infective diseases. Opinion is unanimous that "open-air" or hygienic treatment is the most potent weapon against the attacks of the tubercle bacillus, except in advanced cases.

To aid the natural immunity, to improve the power of resistance, and promote the process of repair are the objects of this treatment, and this can be best attained in a suitable sanatorium.

The evolution of this treatment during the last half-century is well known. It was foreshadowed in England by Bodington and others fifty years ago, but in Germany it was developed and systematised, and the measures for the control of the disease are now more complete there than in any other country. (b)

In British sanatoria, German methods have been modified in various ways. Without detracting from the merits of the foreign system, experience shows that some details can with advantage be altered or omitted as unsuited to English character and habits. The general principles and routine of treatment in most British sanatoria are similar, however they may differ in details. The main factors may be summed up as follows:—

1. Pure air always.
2. Abundant sunlight.
3. Regulated rest.

(a) *Lancet*, August 8th, 1903.

(b) Bulstrode, *Lancet*, August 8th, 1903.

4. Graduated exercise.
5. Abundant nourishing food.
6. Careful medical supervision.

1. *Pure Air*.—The history of Arctic exploration shows that in those frigid regions there is remarkable immunity from rheumatic affections, catarrhs, and common colds. The doctor to the Italian expedition (a) which reached the furthest North comments on this significant fact, and attributes it to the purity of the air and the absence of micro-organisms, the cold and the continuous and intense light being antagonistic to their development. Other Arctic explorers record similar facts.

The microbes to which are due catarrhs, influenza, common colds, and such like infest ordinary houses, but do not exist where the air is kept pure. In open-air sanatoria such ailments are unknown, unless they are imported, and even then they are short-lived.

The first aim of the treatment is to substitute pure air constantly for the unclean and vitiated atmosphere in which most phthisical patients try to live for months or years. An "open-air" life is the first essential of hygienic treatment.

In fine weather the patient can spend the day out of doors with adequate shelter from wind or hot sun. On wet or stormy days he can rest in a suitable shelter or verandah. In most sanatoria huts are erected in different positions, those for winter facing south, and others for summer facing north. Revolving shelters are very useful. Balconies with proper protection from wind, rain, or glare are suitable for weaker patients. At night the head of the bed must be close to the open window. Shelter from strong winds or rain can be secured by moving the bed about, or by some screen arrangement. The larger the window space the better, since the air of the room is more easily kept pure, and there are fewer spaces for stagnant air. It has been found that febrile patients do better in a chalet with windows on all sides than in an ordinary bedroom with open windows. The furniture must be scanty; carpets, curtains, wall-papers, and everything that can harbour dust should be abolished. Hence the walls should be smooth, varnished, or dis-tempere; the utmost cleanliness is essential, and proper precautions taken regarding sputum and disinfection.

The constant purity of the air causes night sweats to disappear; sleep comes readily; cough and fever lessen; increased appetite comes, and at the end of the first week there is usually a gain of some pounds in weight. Every patient should have a separate bedroom to prevent disturbance by talking, coughing, &c., and to ensure privacy and rest. Of course, in public sanatoria this is sometimes difficult, though various simple kinds of hut can be erected cheaply; but in private sanatoria it is the rule. Personal experience of a wooden chalet in an English winter convinces the writer that it is then fit only for stronger patients with a good circulation. Delicate consumptives require more comfort and warmth than can be attained in a fragile wooden structure. At other seasons of the year it has its advantages. The site should be specially chosen to give pure air, with shelter from strong or cold winds. Hence it should be in the country, away from dust, smoke, fog, or noise; isolated, and in its own grounds. It is quite out of place in or near a town.

An elevation of some hundreds of feet above sea-level gives bracing and invigorating air as well as more ozone. Anyone who has lived in a low-lying place and migrated to the uplands must readily admit his improved health, energy, and sense of well-being.

The elevation must not be too great on account of severe cold and gales in winter. Visitors to British sanatoria will find them in varied positions, and doubtless some cases do best in low, sheltered places.

It is possible that the situation may be too shut in by hills, trees, hedges, &c., so as to prevent free circulation of air, especially in summer. Nearness to the sea is not an advantage. Practical men generally

advocate a site elevated and airy, but not too exposed or wind-swept.

The experts who advised regarding the King's Sanatorium recommended a high situation on the slope of a hill facing south, with adequate shelter from prevailing winds. An ideal position is hard to find, free from every drawback, and in the country the question of supplies has to be considered. The nature of the soil is important. It should be of a porous nature, readily drying after rain. Damp, heavy clay soils should be avoided.

2. *Abundant Sunlight*.—A high situation gets more sunlight than a low one, where morning and evening mists are liable to prevail for several months in the year. A number of places in the British Isles get a fair amount of sunshine even in winter.

In the *Lancet* (April 16th, 1904, p. 1071), comparison is made between the winter temperature chiefly of the South of England and the Italian and Rivieran resorts, not all to the advantage of the latter; while as regards diurnal range of temperature and freedom from frost, the English places are superior. The aggregate rainfall of these home stations was lower, though there were more wet days.

Dr. Gordon, of Exeter, has written on the injurious effects of wet winds in phthisis. There is no doubt that bronchitic, elderly, and some febrile cases do not improve then as they do in dry weather, but, with care, ordinary cases make fair progress. During bright, frosty weather patients do well. The climate of Scotland is not a choice one, yet patients in sanatoria there get on well. It is extremely doubtful if dry climates, which have drawbacks of their own, such as hot winds, dust, sudden changes of temperature, &c., are generally beneficial, except for a few months in the year. Hot, semi-tropical, or relaxing places are injurious.

There is no ideal climate for tuberculosis all the year round. It is quite certain that a large proportion of cases get well at home, notwithstanding spells of wet or sunless weather. The cosmopolitan observes that many vaunted climates have disadvantages, and that patients get cured in the most diverse places, so that some ignore the factor of climate. This is doubtless an extreme view. A place suitable for one does not benefit another, and these peculiarities are worthy of study. As a practical rule, the consumptive is best cured in the country in which he has to live. Those who migrate to sunnier climes do not always show the best results; in fact, some have returned with advantage to British sanatoria. Good authorities state that a patient who does not improve in a home institution is not likely to get well abroad. The drawbacks of expatriation, disregard of proper régime of treatment, &c., are apt to outweigh the advantage of more hours of sunshine. The means and social position of the patient also have to be considered.

3. *Rest*.—Most cases on admission require prolonged rest. The fatigue and excitement of the journey are apt to draw on the scanty balance of strength that remains to their credit, and they have to make up arrears of long standing. Few recognise the gravity of their condition, and some are rash or restless, ignorant or careless. Pyrexia and fatigue have been disregarded, and the excitement and distractions of business or pleasure have prevented the requisite repose. The breathing and heart's action have been unduly hurried by day, and by night the fever and cough have caused broken sleep. So the power of resistance is gradually undermined, until a timely surrender is enjoined.

In a sanatorium all this stress and strain is vigilantly stopped. All sources of excitement or worry are removed, and in the quiet routine, pure country air, with companionship of others undergoing like treatment, the patient soon learns the value of rest.

Various conditions, such as hæmorrhage, high temperature, debility, &c., indicate complete rest in bed or on a couch. The effect of proper rest on pulse and temperature is generally marked. Patients rest lying down during the hour before lunch and dinner, talking

(a) "Voyage of the Polar Star." By the Duc d'Abruzzi.

being discouraged. In some places the hour after meals is also thus spent. The patient thus comes to his food with quiet pulse and breathing; not hot or tired, and the process of digestion is undisturbed. Liegehallen, where a number of patients rest together, are objectionable, as preventing proper quietude during rest hours. However beneficial the sociability may be, there is the risk of undue talking, laughing, arguments, or even petty quarrels. Hence in some places the patients spend the rest hours either alone or two together. Experience shows that proper rest and quiet are essential. Some authorities have advocated constant rest, but this is not now adopted, except for some cases.

4. *Graduated Exercise.*—This is one of the most important factors of the treatment. Brehmer insisted on this, and his views bear the test of trial. There is hardly any way by which consumptives do more harm to themselves than by injudicious exercise. Extension of disease, hæmorrhage, increased pyrexia, &c., are thus caused. Hence exercise is given gradually and tentatively, at first a slow short walk on the level with frequent rests. The effect on temperature and pulse are noted. Discussion has arisen on the influence of exercise on temperature, and the relative value of rectal and oral temperatures. Dr. Kelynack (a) has shown that for all practical purposes in a sanatorium the oral method is trustworthy. Though a febrile condition generally indicates rest, some such patients do not improve until limited exercise is taken. Walking is the usual exercise, the pace being regular and slow, two to two and a half miles an hour. As strength is gained, the walks are longer. Gentle ascents are made, the uphill being at the beginning, and the downhill at the end, in order to lessen fatigue. The extent and direction of the walk are daily prescribed, according to the state of the patient and weather conditions. The force and direction of the wind are noted, and for weakly patients sheltered walks are chosen. Rests are frequent, at the furthest point of the walk, and if there is coughing or shortness of breath. To send patients together in chattering groups is objectionable. The direction can be varied to suit individual tastes and capacities, and a time limit is advisable. No weather should deter the stronger patients, but resting in wet clothes, or on wet seats or grass, is very questionable. At length, walks of several miles are given. Hill climbing is encouraged, and some simple form of drill, with breathing exercises, is beneficial when the disease is quiescent. An upright carriage when walking is advisable in order to correct the slouching gait to which consumptives are prone.

There is no doubt of the good effect of hill-climbing for suitable cases, and it is a feature of the treatment in some places. To apportion the due exercise to each patient requires experience and judgment. Most of them are inclined to overdo it, and if left to themselves to go wrong. Those who enjoy their exercise generally derive full benefit from it, but there are some who regard quiet country walks as a weariness to the flesh. The beneficial effects of graduated exercise are certain. The general condition is improved, useless fat got rid of, respiratory power and chest capacity increased, and muscular vigour accompanies gain in weight.

5. *Diet.*—The diet should be specially chosen. It should be plentiful, nutritious, and easily digestible, containing much proteid and fat. Three good meals a day are usually given, with a half to a whole pint of milk at each. Milk is also given at stated intervals. Fats such as butter, cream, honey, are insisted on, equivalent to about 2 ozs. of butter daily.

The appetite of most patients is uncertain and capricious; they are often fastidious and peculiar in their tastes. The disease being a wasting one, it is essential that much nutritious food be taken daily, hence firmness is required to induce them to take enough. Many will shirk it, if they can. Hence the doctor prescribes the food, and sees how they eat it. The indiscriminate stuffing once in vogue is now not

generally adopted. To fill to repletion dyspeptic patients with indigestible food to act as an emetic does not commend itself. Experience shows that less food in proper proportions gives good results. Much has been written on the value of different diets, metabolism in consumption, &c. Cases with active disease and pyrexia require careful and systematic dieting. Most patients soon eat well, and weak digestions improve. Such medicinal fats as cod-liver oil, maltine, &c., are very rarely required. The gain in weight is usually 1 to 2 lbs. weekly, or more, though too much value must not be given to this, for it is an uncertain index of real progress. The disease may progress, though the patient gets heavier. Even febrile patients will gain weight if they eat well and are kept quiet. More weight without condition is not the object of this treatment. Since many consumptives have bad teeth, and some pyorrhœa alveolaris, the services of the dentist are required.

6. *Medical Supervision.*—Some writers regard this as one of the main factors in the treatment. Dr. Knopf, in his practical essay on "Tuberculosis," records that "after visiting the chief sanatoria in Europe and America he is convinced that the tuberculous patient has the best chance of getting well only when he is under constant medical supervision." Dr. Latham, in his prize essay, quotes the statement of Solly to the effect that "in the beautiful climate of Colorado there is enormous difference in the mortality among consumptives under medical control when compared with those who merely consult a physician when they think necessary."

The disastrous effects of this lack of medical control are frequently seen in cases when admitted. In the patients' interest there must be discipline, which insists on essentials, but is lenient in minor details. A slavish adherence to routine or easy-going laxity are extremes to be avoided. To quote Dr. Latham, "The physician must be autocrat, his word must be law. He must be prepared to give his entire energy to the work, for, as Dettweiler has expressed it, "a sanatorium must be his religion, his politics, his despair, and his delight."

In charitable institutions where patients err through ignorance, the discipline must be strict. If located near a town, there is risk of temptation, frequent visitors, and violations of the canons of open-air treatment. In private sanatoria for the better class, to judiciously relax rather than tighten the bands of discipline, to lessen the irksomeness of restraint, while insisting on essentials, seem to be the aims of thoughtful medical superintendents. "All sorts and conditions of men" are found in sanatoria, and in ruling them common sense and tact are required. The office is no sinecure. To quote Dr. Knopf: "Consumption is not an easy disease to treat. It requires a thorough knowledge of the etiology, pathology, and therapy, and a familiarity with all the symptoms of the disease, but also a great deal of devotion and patience combined with strength of character." He leads the same kind of life as the patients; he sees them regularly, prescribes their food, exercise, and rest. He is their guide, philosopher, and friend, and encourages friendly rivalry in well-doing. He prevents undue excitement, and discountenances visits of talkative friends. Dr. Latham wisely warns against the temptations of sexual excitement. Among young, idle, well-fed patients some will be erotic. Hence some separate the sexes in their walks and rest hours. Sexual excitement in a consumptive is such a bar to recovery that it should be prevented. Anyone who knows a large sanatorium will admit that not only patients, but nurses and servants, want watching in this regard. Of course, careful discrimination is necessary.

The enforced idleness is apt to cause moral deterioration. The listless lounging and vacuous aspect occasionally observable may be prevented by quiet recreation or occupation. A gentle game of croquet or golf, a drive or picnic, help to vary the monotony. Various quiet games, hobbies like photography, botany, natural history, &c., may be encouraged. The

(a) *Brit. Med. Journ.*, October 24th, 1903.



musician or artist need not quite be debarred from his vocation.

The poorer class of patients need some work such as gardening or quiet household tasks. The whole subject needs careful consideration.

#### DURATION OF TREATMENT.

The usual time of treatment is three to six months, sometimes longer. When there are marked physical signs, the initial stage is past, and the extent of the disease is always greater than shown by physical signs (Gee). Tuberculosis is mostly a slow disease. The element of time is necessary for the process of tissue change which constitutes complete arrest. Trivial causes check recovery. Relapse is easy, unless care is taken, and many patients forget hygienic rules. Hence the prognosis should be guarded, and the optimism that predicts a speedy cure is found occasionally false.

#### UNFIT CASES.

Sanatorium treatment is not suitable for all tuberculous cases. The following may be held unfit:—

1. Age below puberty, or too old.
2. Bad family history and physique.
3. Temperament unfit. Irritable, neurotic, reckless, or alcoholic.
4. Chronic bronchitic cases, with tuberculosis.
5. Elderly dyspeptic cases.
6. Those who bear cold badly.
7. Advanced cases with extensive lesions.

Some sanatoria do not admit hopeless cases, which require comfort rather than cure. All unfit cases may be treated elsewhere by some modification of open-air methods.

#### RESULTS.

In Germany where statistics (a) are available, 85 per cent. of patients are improved, 16 per cent. unimproved, 0.8 died; only one-sixth did not recover their power of work. Those in the so-called first stage, with consolidation of one lobe or two half lobes, without cavity, show the best results. The statistics of English sanatoria are not available, but those published show similar results. Most cases except those in an advanced stage show great improvement. The early cases, as a rule, leave the sanatorium with no symptoms of the disease, slight physical signs, absence of bacilli in sputum, and robust in appearance. In more severe cases there is reduction of fever and pulse rate, less cough or night sweats, better breathing, and gain in weight and muscular power.

It is quite certain that results will be better still, as more suitable cases are sent and the unfit eliminated. The limitations of the treatment and the advantage of sending cases in the early stage are more generally recognised. Procrastination or a late diagnosis do not enhance the prestige of the medical adviser.

Many of those who complete sanatorium treatment are fit to enter again on the toils and joys of life, provided they follow some outdoor calling, free from arduous exertion or strain. Some have even gone back with impunity to employments where an open-air régime is impossible. Others are unfit for work, owing to lack of robustness, but with care and out-door methods they may live to old age. Occasionally the improvement is transient, but this is mainly due to carelessness, over-exertion, or bad hygiene.

Sanatorium treatment is no specific against tuberculosis. Many details are mainly empirical, but as its main principles inculcate a return to a natural life, instead of the artificial modes of so-called civilisation, even for its educational effect it is of great value. Hygienic treatment is beneficial for many other conditions of ill-health besides tuberculosis. Those of us who live the free open-air life, and who see the good effects of it on servants, nurses, and others, would not readily return to the doubtful blessings of ordinary life. The results of this treatment of tuberculosis far surpass any other, in the cure, arrest, or alleviation of one of the most prevalent of the "ills that flesh is heir to."

(a) *Tuberculosis*, April, 1903. Bulstrode, *Lancet*, July and August, 1903. T. Williams, *Lancet*, January 30th, 1904.

## British Health Resorts.

### IV.—BISHOP'S-TEIGNTON.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

AMONG the many fair villages of Devon which justly claim the attention of the health-seekers, Bishop's-Teignton deserves to occupy a foremost place. It is charmingly situated on the north side of the Teign Valley, about 200 ft. above sea level, and can be easily reached either from Teignmouth or Newton Abbot. An omnibus runs to Teignmouth (two miles) three times a day (fare 6d.). Teignmouth (20½ miles) can be comfortably reached from London by the Great Western Railway in about four-and-a-half hours. Passengers may also travel from Waterloo to Exeter by London and South-Western Railway in 3¼ hours, and thence proceed on the Great Western system. Bishop's-Teignton offers many attractions. It is sheltered from the cold winds on the north-east by the heights of Haldon, which rise to 800 ft.; this renders the village excellent as a winter resort. To the south are delightful views of the Teign Valley, while away to the west stand out the highlands of Dartmoor. On the east near at hand lies the open sea. The place is well exposed to sunlight, protected from trying winds, and combines something of the advantages of moorland breezes with the invigorating elements of a marine climate. The village is clean and picturesque, and over all there prevails a restfulness peculiarly soothing to the invalid and overworked worker. In these days of stress and strain, Bishop's-Teignton can offer rest for body and goes far to secure peace of mind. We particularly recommend it for the overworked, the convalescent, the invalid, and the aged.

Good apartments can be obtained in the village, but the visitor who is in search of health will do well to visit the well-known hydro, "Huntly," conducted by Mr. C. F. Carpenter. It has much to offer for the jaded and overworked. The situation is excellent, and the extensive grounds are well kept and afford views of great beauty. The house has been extended from time to time, and now an extensive suite of rooms exist, and they, together with the hall and corridors, are well heated in cold weather. Accommodation is provided for about forty visitors. Here a hygienic life can be lived which should allow of recreation of body and rejuvenescence of mind. Carefully selected baths, good food, pure air, attractive walks, pleasant drives, and much cheerful society supply the chief therapeutic factors for re-invigoration. Quiet outdoor pursuits may be enjoyed in plenty. A medical attendant provides for the requirements of the really sick.

Natural and artificial forces have combined to make Bishop's-Teignton a very desirable health station for an important section of cases requiring medical direction, and we have no hesitation in drawing the attention of medical men to its advantages.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 31st, 1904.

### TREATMENT OF LEAD COLIC.

PRUDENCE should be observed, says M. Feissinger, in the treatment of lead colic, for in reality the case might be one of appendicitis in which drastic purgatives would be dangerous. Hitherto, before appendicitis was as well-known as to-day, energetic purgatives were recommended, but with our present knowledge, to have recourse to them might sometimes be disastrous.

Saturnine poisoning does not always appear under the classical form; the diagnosis is sometimes difficult. The cardinal symptoms are not always all present; only one may remain—pain—while the others—constipation, vomiting, retraction of the abdomen, may be absent. Certain patients suffer from diarrhoea and



tympanitis, while in others fever is present. Contrary to the rule, certain colics are more painful to deep than to superficial palpation. Renal and hepatic colic are easily recognised by the special seat and character of the pain, but other affections might be taken for lead colic and of these, appendicitis is one of the most difficult to distinguish in chronic saturnism, especially as patients have been known to have attacks of both these maladies alternately.

Consequently, great circumspection should be observed in the treatment of lead colic. Drastic purgatives should be excluded; saline purgatives, sulphate of soda, or magnesia, associated with senna, should be preferred. But of all the evacuating agents, olive oil is the best, given either in one dose of six ounces or an ounce and a half each morning. Enemas of hot water have been recommended by Tripier, of Lyons.

To ease the pain injections of morphia are generally given, but opium pills, one to two grains in the twenty-four hours, are equally good. The Lyons doctors associate belladonna and antipyrine, the belladonna in one-third grain pills, three or four times a day, and from twenty to sixty grains of antipyrine in the twenty-four hours.

Where gastric intolerance is present, suppositories of opium and belladonna will be ordered; while the abdomen will be rubbed over with belladonna ointment. When the pain has ceased a mixture of sulphur and honey may be given and the patient recommended to take sulphur baths.

#### TREATMENT OF INFANTILE SYPHILIS.

The treatment, according to Dr. Leon de Keyser, should be at first maternal, that is to say, through the milk of the mother, who will continue the treatment begun during her pregnancy, and if this had not been prescribed, the mother will immediately be placed under the influence of the mercurial treatment. As to the child, rubbing in of mercurial ointment is very efficacious, and well borne, as it rarely produces salivation. The state of the skin, however, should be attended to, and the ointment should not be repeated on the same spot before a few days. Each day, one or two frictions should be made with a piece of flannel coated with a very small amount of mercurial ointment, ten to twenty grains. If diarrhoea sets in or the skin gets inflamed, the treatment should be suspended.

If internal treatment is prescribed, preference should be given to bichloride of mercury or calomel. The former is given in Van Swieten's solution or 1-1,000. From half to one drachm of this mixture might be given daily in milk, in three or four doses, and continued for months. Calomel gives excellent results at the dose of one-fifth of a grain three times a day. Monti prescribed—

Calomel,  $\frac{1}{2}$  gr.  
Lactate of iron, v. gr.  
Sugar, oz. iss.

Divide into ten powders, one to four daily.  
Taylor prescribes—

Bichloride of hydrarge,  
Iodide of potassium, iii gr.  
Syrup of orange water oz. ij.  
Five to ten drops three times a day.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 31st, 1904.

In the *Therapie de Gejenwart*, Dr. Klienberger has a paper on

#### RECTAL FEEDING IN ULCUS VENTRICULI.

A wound, he says, heals up the more rapidly the less its

edges gape. An ulcer of the stomach heals the more rapidly therefore, when the stomach is contracted. It is in a state of greatest contraction when hunger is felt. Although there is difference of opinion among physicians how long the stomach should be kept empty, it is quite certain that no food whatever should be given by the mouth for some days after hæmorrhage from the stomach. It has been shown clinically that human life can be kept up for weeks by rectal feeding. Strauss mentions a case in which a man was fed exclusively by the rectum for seventy days. If a combination is made of egg, starch, and sugar enemata and oil subcutaneous infusion 2,000 calories may be given daily. No hyper-hydrochlorydia is present in an empty stomach. The usual nutrient enemata do not excite gastric secretion but it would be as well to omit red wine as an addition to the enemata.

It has been concluded by some that the abstinence cure is not sufficient, as not enough account has been taken of the anæmia present. The author looked into this question in the case of thirteen patients, who were being treated. The blood was carefully examined. The treatment had consisted in absolute rest for at least three weeks after the abstinence period; occasionally, infusions of 1,000 to 1,100 cc.m. of physiological saline solution were given. The nutrient enemata were given three times a day, and they consisted of 200 to 400 cc.m. of milk, two to three eggs, one teaspoonful of salt, one tablespoonful of sugar, and one of plasmon. If required, twenty-five drops of tincture of opium were added. An hour before the enema the bowel was washed out with water. Occasionally in the evening the saline solution was given by the bowel instead of subcutaneously.

The patients were under treatment for two months. Two died, one a girl, from hæmorrhage from the superior coronary artery, the other, a young man, from hydrochloric acid cauterisation; whilst drunk he had swallowed 130 grms. of raw hydrochloric acid.

The examination showed that during the extra-buccal treatment the body weight, blood pressure, and pulse curve sank moderately. The lowering of blood pressure did not usually exceed 30 mm. The hæmoglobin only appeared to diminish when the bleeding continued. The erythrocyte cells remained constant or rose slowly. They only sank to a corresponding degree when the hæmorrhage was severe and continuous.

The blood constituents in any case did not suffer from the rectal alimentation, and the power of the heart was not lowered.

At the Medical Society meeting Hr. Immelmann gave a short account of

#### LONDON'S LATEST EXPERIMENTS WITH RADIUM.

A bottle was filled with a solution of radium bromide and was brought into communication with another by means of a glass tube. In this second vessel were placed various objects, such as glass, iron, lint. He was able to show that by examination the properties of the radium were extended to these objects. Frogs and mice upon which these emanations acted, died and their cadavers were photographically active.

At the Society of Charité Physicians Hr. Heubner showed a child suffering from swelling of the eyes, constipation and wasting. It showed cachexia, swelling of the face and dyspnœa. On the right side of the chest was a projection that gave a dull sound on percussion. This reached in the axillary line to the fourth rib, and towards the left to the sternum. The physical condition was confirmed by radiogram. According to percussion there was no connection with the heart; the breath sounds over the dulness were weakened. As the dulness extended on expiration it

might be taken that the tumour was not in the lungs. It was therefore a mediastinal tumour, probably an enlarged thymus. The urine contained albumin. The swelling of the face was caused by stasis from pressure of the tumour on the superior vena cava. The paleness was due to the character of the blood, which contained 2,000,000 red blood corpuscles, 92,000 lymphocytes to the cubic centimetre, and a few polynuclear leucocytes. Nothing would do good except extirpation of the tumour.

Hrn. Kraus and Senator were of opinion that operation gave absolutely no prospect.

Another case shown was one of

#### INFANTILE MYXŒDEMA.

It was the case of a child of two, that although well nourished, at first developed slowly both mentally and bodily. For example, it had never laughed, it was not directly weak-minded, but weak in reaction and abnormally quiet. The face of the child was without form, thick, swollen forehead, narrow eyelid fissures, saddle-shaped nose, thick lips, and scanty hair. The skin was dry and thickened in many parts. The tongue was so much swollen that it appeared between the lips, and there was an umbilical hernia. The thyroid could not be felt at all. To the symptoms of myxŒdema of the adult were added faulty development of growth. It was like a cretin. The pulse was slow. The treatment consisted of Merck's thyroid preparation in doses of 0.025 to 0.05, and 0.1 grm.

There was a diminution in the formation of urea.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 30th, 1904.

#### SUDDEN DEATHS IN TYPHOID.

At the Prague meeting, Velich drew attention to the recent expressions of Koch with respect to sudden deaths from latent typhoid, which he affirmed are very frequent. On that occasion he set down a rule that no patient should be released from isolation till no typhoid germs could be seen after three examinations of the stools. He assured the meeting that this was not an inconvenient regulation to establish, and that he had performed thirty-six post-mortems on such epidemiological sudden deaths, and found twenty-seven of them suffering from heart disease, old pleural attachments, kidney, liver, brain, or lung affections. The other nine were undefined cases which might come under Koch's description, but might be due to other causes as they had previously been confined to bed, to house, or hospital. Again, many cases of typhoid are so slight as to escape attention, and therefore distribute the disease more widely than the small number that may die. He thinks the vigilance of the past is better than the present proposal to confine a few unduly on suspicion.

#### BROMO-DERMA TUBEROSUM.

Samberger exhibited an epileptic, æt. 12, with a large swelling over the triceps brachii, depressed in the centre and covering an area as broad as the palm of the hand at the base, and tapering to the size of a florin at the apex. Around the upper margin were small pustules, while the whole growth tended to increase as is usual in these cases.

#### CONGENITAL PROMINENCE OF SCAPULA.

Jedlivka showed a girl, æt. 13, on whom he had operated for a projecting scapula on the left side. From the inner side of the shoulder blade a hard bony connection was observed that held the scapula up alongside the neck. In the operation to relieve the band Maydl found that the bony connection was firmly

incorporated with the sixth cervical vertebræ with a cartilaginous articulation at the scapular margin. On dividing the bony attachment at the arch of the vertebræ the spinal canal was opened and the dura mater injured. With careful attention the wound healed and the scapula fell to its normal level, leaving the patient strong, with a free movement at the shoulder.

He also showed a boy, æt. 10, who underwent a similar operation for the same sort of bony connection. Maydl considers this a supernumerary rib springing from the last cervical vertebræ and to remove the deformity nothing short of extirpating the abnormal bony connection is available. On looking through the literature on the subject, Maydl finds the term Sprengel's deformity attributed to this malformation, which was in existence and recognised long before Sprengel's time.

#### EXPERIMENTAL ENDOCARDITIS.

Prochazka then gave the Society a history of his efforts to produce endocarditis in animals. The question has often arisen is the microbe the chief factor in the production of endocarditis, or is it a second agent in the train of symptoms. Leube some time ago affirmed that the primary factor was a toxin that first acted on the endothelial cell and so weakened its vitality, that the secondary infection had an easy task in producing the inflammation.

In order to test this theory with practical facts Prochazka commenced his experiments by injecting ten dogs repeatedly with toxins of different microbes, till a condition of toxæmia was produced, when a specific microbe would then be introduced, into the blood by the veins with the hope of producing endocarditis. Of the ten dogs operated on only one survived the ordeal of the intravenous injection of the microbe, while all the control animals or those treated with the toxin recovered. Eight of the nine died from septicæmia and only one was free from endocarditis at the post-mortem; some were of the verrucous form, others assumed the ulcerative form, while others had both forms in combination.

None of those treated with the toxin treatment only had any sign of endocarditis. He therefore concludes that the toxins are the predisposing factors in the production of endocarditis. He pointed out that the same microbe may first provide the toxin in the blood till toxæmia is produced, and then with its actual presence excite the inflammatory endocarditis. This form of production is now known by the method of "Homogenic Infection," the other method is when a toxin has produced the toxæmia and a foreign microbe is introduced with the same result that it receives the name of "Heterogeneous Infection." It is worthy of note that the lesions induced in these animals were located to the same areas as described in pathological works, which is probably due to mechanical causes in the course of the endocarditis, such as rubbing or impact on the blood in the cardiac contractions.

Velich remarked that dogs were not suitable animals to perform experiments of this kind on, as 60 per cent. of the healthy dogs would be found to have endocarditis, more particularly if they were advancing in years and with urethral discharge.

Ottokar Kose expressed surprise at these results as he had experimented in the same manner with twenty-six dogs and only in one single case had he a positive result, and strange to say this was with a streptococcus culture!

Prochazka in replying, said that Velich must be confounding degeneration and atheromatous changes in the heart for acute endocarditis, which he recognised.

#### SULPHO-CARBIDE POISONING.

Vanysek showed two patients whom he had treated

for sulpho-carbide poisoning. The patients were engaged at an indiarubber works, where vulcanising was carried on in a very confined room, which was badly ventilated. The symptoms were motor enfeeblement of the lower extremities, paræsthesia, impotence, and mental depression. The objective examination revealed polyneuritis, tremor in hands and head, increased vaso-motor reflex which was present in the muscles also, muscular weakness, tactile anæsthesia of the skin, paræsthesia, and increased patellar reflex. One of them had the pseudospastic paresis of Nonne.

He further recorded the history of two other similar cases with Erb's symptom, expiratory retardation of the pulse with orthostatic tachycardia. These last symptoms he contended had never been recorded as being associated with sulpho-carbide poisoning.

#### MYÆSTHENIA.

Haveroch showed a few cases of progressive paralysis. One female knew she had it, but could not tell when it commenced. A young girl with myæsthenia could walk a short distance, but had to stand unable to move when the muscles were tired; if she held out her right arm her left became paralysed. There was no pain anywhere, only loss of motor power causing her to stand like a statue when the muscular power ran out. Her father was afflicted with the same malady.

## The Operating Theatres.

### GREAT NORTHERN HOSPITAL.

REMOVAL OF APPENDIX.—Mr. PEYTON BEALE operated on a man, æt. about 30, who had been admitted one week before with an acute attack of appendicitis. The patient had a history of three or four similar attacks previously. At the time of operation, all acute symptoms had passed off, but there was a swelling to be felt in the pelvis on the right side, and this swelling appeared to extend towards the inguinal canal. It was supposed to be a case of enlarged appendix, possibly bound down by adhesions. The abdomen was opened so as to expose the cæcum. This was brought out with considerable difficulty owing to adhesions binding it down in all directions. A large mass was found behind the cæcum involving the base of the appendix, which contained a small quantity of pus. This, Mr. Beale pointed out, was quite unexpected, seeing that all acute symptoms had been in abeyance for four or five days previous to operation. This pus was carefully washed away and the rest of the appendix sought for. There was considerable difficulty in finding it, as it was behind the cæcum and very much bound down by adhesions. When it was found it was seen to be firmly adherent to the spermatic cord, from which it was separated with great difficulty. Its various adhesions having been ligatured, the appendix was removed in the ordinary way and the wound closed. Mr. Beale said that this case was remarkable, first, because pus was actually found at the time of operation, although every acute symptom had passed off some days previously. This was, of course, not really a very uncommon occurrence, and he believed that in many of the cases of recurrent appendicitis a small abscess such as was found here persisted between the attacks and that, however long the surgeon waited before operating, he could never be certain from the patient's symptoms and general condition that pus was not present. It was of course encapsuled, but none the less must necessarily be a source of considerable danger when an operation for the removal of the appendix is undertaken. The case was of interest

secondly, he thought, because of the adherence of the appendix to the spermatic cord; he had not previously come across this condition, and at first sight it was not at all easy to realise that the structure was the spermatic cord, or to see how the appendix could have become adherent to it. Such a condition could, he supposed, only occur when the appendix was behind and below the cæcum, and of unusual length, as it turned out to be in this case. The patient had suffered no unusual pain, nor were there any symptoms beyond those of an ordinary recurrent acute appendicitis.

### NORTH-WEST LONDON HOSPITAL.

OPERATION FOR ACUTE INTESTINAL OBSTRUCTION FOLLOWING AN ACCIDENT.—Mr. MAYO COLLIER operated on a case of obstruction, the history of which was as follows:—Five days previously the patient, a publican, æt. 64, fell down the steps of his cellar on to some barrels. When examined by his local medical attendant, a fractured fifth rib was discovered. This was efficiently strapped and bandaged, and the patient advised to keep his bed. The following day the man felt very sick and vomited once or twice. There was complete anorexia and some commencing distension of the abdomen. This state of things becoming gradually worse, the case was admitted into the hospital. On admission the pulse was 120; there had been constant coffee-ground offensive vomiting for two days; the abdomen was enormously distended and tympanitic all over, and respiration was much impeded. The tongue was extremely foul, and the patient's general condition was very grave. Mr. Collier decided on immediate abdominal section. An incision was made above the umbilicus about four inches in extent. On opening the peritoneal cavity a much distended stomach protruded into the wound. The stomach apparently filled the whole upper part of the abdominal cavity. After puncturing with a fine needle and letting out a great quantity of offensive gas, Mr. Collier was enabled to introduce his finger into the peritoneal cavity above the small curvature. This was followed by the outflow of at least half a pint of blood and serum. The rest of the abdominal cavity was carefully explored, and the distended small intestine punctured in several places with a small needle, much gas escaping. Nothing abnormal was discovered in the rest of the abdominal cavity. Having carefully sponged the region between the pylorus and the liver, Mr. Collier closed the abdomen, and the patient was returned to bed. Mr. Collier said this was an extremely interesting case. The man was perfectly well before the accident, but yet symptoms of acute obstruction of the bowels supervened slowly after the fall. From the condition of the stomach, its acute distension, the coffee-ground vomiting, that took place before the operation, and the amount of blood in the upper part of the peritoneal cavity near the small curvature, this was evidently, he pointed out, a case of acute obstruction due to ileus following a blow in this region. The distension was so acute at the time of the operation, he said, that a considerable time had to be spent with a fine hypodermic needle in removing the gaseous contents of the bowels before the finger could be introduced to examine the abdominal cavity. This procedure was, in fact, he considered, the most important part of the whole operation, as it was in order to allow the bowels to recover themselves and to take off the pressure of the distended stomach.

From the time of operation the sickness ceased, the distension subsided, and the patient made an uninterrupted progress towards recovery.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 3, 1904.

**THE BRITISH MEDICAL ASSOCIATION MEETING.**

THE Annual Meeting of the British Medical Association at Oxford has been the occasion of a more than usually brilliant gathering. This ancient University town has witnessed three such meetings since the first one held within its gates in 1835, attended by some 300 members. The progress of the Association has been rapid, and hundreds have been converted into thousands, so that the total number of members now reaches 19,000. The possibilities of such an organisation are incalculably great, and signs are not wanting that its fulness of power will shortly be exerted in defending the material interests of a profession that is sadly in need of protection. The president of the 1904 meeting, Dr. William Collier, found at hand a fruitful and interesting theme on which to base his discourse, namely, "The Growth and the Development of the Oxford Medical School." The teaching of medicine in that ancient seat of learning has been continuous since the great scientific Englishman, Roger Bacon, lectured within its walls. Since his days the names of such famous men as Linacre, Harvey, Sydenham and Radcliffe have become famous in connection with the study of medicine at Oxford. It is only within comparatively recent times, however, that science has been established on a firm footing in the University. Indeed, the revival of the Oxford Medical School may be said to date from the building of the museum in 1855. Since that date science has been simply revolutionised, a fact noted by Sir William Church in delivering the Address on Medicine. The last meeting in Oxford took place in 1868. It was only the year previously that Lister read at Dublin his paper on "The Antiseptic Principle in the Practice of Surgery." At that time the probability of the infectivity of tubercle was beginning to be esta-

lished. Sir William pointed out that the exact knowledge furnished by bacteriology and other branches of scientific research have had a greater influence on state or preventive than upon clinical medicine. Perhaps the most important part of his address was that which dealt with the relations between medical officers of health and the administration, both local and central. He instanced the attitude of the medico-political and public health committees of the Association in their proposed Bill to reform the public health department of the Local Government Board. The chief clause urged that the medical element should exercise greater weight and authority at Whitehall, and that "the medical officers of health throughout the country should be responsible to the Local Government Board, as well as to the local authorities." Under existing conditions the medical officer of health in the majority of cases simply courts dismissal if he acts fearlessly and progressively in the sanitary interests of the community. Other points in this most interesting Address will repay careful reading, not only by medical men, but by the outside public, to whom preventive medicine is a matter of profound and vital importance. Turning to the "Address on Surgery," we find an able address from Sir William MacEwen, who worthily maintains the illustrious traditions of Scotch surgery for brilliance and originality. The main part of his remarks he devoted to the choice of suitable material for ligatures and sutures, to their absorption and to the absorption of catgut and chicken-bone drainage tubes. Attention to details of this sort, it need hardly be remarked, are absolutely necessary to operative success. A novel feature in the Oxford programme was the delivery of a popular lecture by Dr. Ferguson, of Cheltenham. He chose as his subject, "Disease Germs," and discussed their nature and significance in disease, together with their appropriate preventive and curative methods. On the whole, the scientific side of the meeting has been well up to the average, while the social side of the annual meeting has been of an unusually brilliant character.

**SEASIDE THERAPEUTICS.**

THE seaside is probably the most ancient of health resorts. People have flocked to it in the hot weather from time immemorial in spite of difficulties of transport, ostensibly for the purpose of restoring their shattered energies, with results that, on the whole, may be assumed to have been satisfactory since the practice still obtains. The choice of a seaside resort is usually decided on grounds of expediency rather than of judicious selection, and the matter is perhaps not one of much importance so far as the healthy are concerned. When, however, we aim at obtaining certain definite effects from the air or in the water in disease it is necessary to form a clear idea of what we require and the likelihood of obtaining it. All seaside resorts are not alike, therapeutically speaking; far from it, a point that is clearly shown

in the communication (a) which we publish on "Seaside Therapeutics." Apart from certain general characteristics, such as uniformity of temperature, atmospheric density and moisture, freedom from dust, and comparative richness in oxygen, the curative properties of seaside resorts vary greatly, accordingly as they are, or are not, protected from wind, are sunny or otherwise, and, last but not least, according to the configuration of the neighbouring country, whether wooded or bleak. Each description of resort has curative qualities of its own, but no one resort is suitable for all classes of patients, even if we exclude those whose morbid predispositions are such as to render residence in the vicinity of the sea undesirable or injurious. The popular practice of sending people with "weak chests" to the seaside is fraught with many, to the physician, obvious risks, and the wise would no more think of adopting this course without obtaining medical advice thereon than they would administer particular medicaments on their own responsibility. It is not a matter of indifference, it cannot truthfully be asserted that if it does no good it will, at any rate, do no harm. The perturbations induced in the human organism by transfer to the seaside, especially before the system has had time to become acclimatised, are often very marked, and, in the delicate, may be attended by grave discomfort, if nothing worse. In the article to which we have referred, sundry practical data are given on which an opinion can be formed as to the suitability of a particular resort in individual cases, for nothing should be left to chance. Medical men as a rule are familiar with the general principles that underlie what may be termed seaside therapeutics, but what they lack is a classification of seaside places into categories according to their local climate and topography. There is room, indeed, for a guide to watering-places, not based on the claims advanced by those who are interested in their future, but reasoned out in accordance with the well-known principles of climatic therapeutics. Much useful work has been done in this direction by the committee of the Royal Medical and Chirurgical Society, but its reports are not accessible to the general public or even to members of the medical profession. Were it not that the curriculum is already over-crowded, we should be tempted to suggest the propriety of requiring some knowledge of balneotherapeutics, a branch of medicine which for some reason has been persistently neglected in this country, though highly appreciated elsewhere. To some extent, however, in late years the gap has been filled by the Balneological Society of London.

#### SUPERSTITION AND PSYCHOLOGY.

THERE has been much fluttering in the journalistic dove-cots over the remarkable dream that Mr. Rider Haggard has thought fit to publish to the world in a letter to the *Times*. Probably, there are few people to whom the circumstances

are not now familiar, but it may be well for the sake of those who have not fully acquainted themselves with its details to recapitulate them briefly. One night Mr. Haggard was awakened by his wife from a confused nightmare in which uncomfortable sensations such as those of drowning prevailed. Between the time of his being aroused and the time that he became fully conscious he dreamed that a favourite dog was lying among rough growth beside water, and that his (Mr. Haggard's) personality was rising out of the dog. The dog seemed to be trying to speak, but could not, yet it somehow conveyed to Mr. Haggard that it was dying. Then he awoke. The subsequent facts may be summed up by saying that the dog appears to have been run over by a train some three hours before Mr. Haggard's dream, and to have fallen over a railway bridge into some water, where he was discovered two days later by strangers. The exact time of its death cannot certainly be determined, but the general probabilities point to the accident having occurred well before the dream; the only alternative being is that it was killed at least twenty-four hours after the dream, as a Sunday, on which no trains ran, intervened. These, then, are the facts, and it is quite extraordinary the hubbub that they have created. Making an allowance for the dreamer's personality being that of a popular novelist, and for the approaching advent of the "silly season," there remains a large gap in the reputation of the Britisher for stolidity that it is difficult to fill up. In every country there exists side by side with the work-a-day individuals a complement of idle quidnuncs, and these are only too glad of any trifling passing sensation, but when journals of the acumen and culture of the *Spectator* take to debating seriously the solution of the "mystery," it is excusable to remark that they might be better employed. Medical men are frequently accused of materialism, and no doubt scientific training tends in that direction, but what is valuable in scientific training is that it never encourages its followers to fly to supernatural or præter-natural explanations for phenomena, till they become inexplicable on natural hypotheses. The gain that the scientific method has been to medicine is inestimable, and not the least of its benefits has been that it has entirely eliminated the crudities of demonism and supernatural interventions from its pathology. Fortunately for themselves, sick persons at the present day, even if they cannot be directly cured, are spared the infliction of undergoing painful and even brutal rites such as were entailed by the practice of exorcisms. To find, then, so small an impression has been made by science on those of our fellow-workers who represent in journalism much that stands for the best in thought and culture, that, in this year of grace, the *Spectator* gravely brings forward a theory of the migration of the spirit during sleep to account for Mr. Haggard's dream, is, to say the least, disappointing. The physiology of sleep—the diastole of the brain, as oster has called it—is admittedly not fully

(a) See "Original Communications," page 112.

understood, but on the analogy of other tissues, it is only reasonable to assume that the most highly differentiated of all tissues needs its periods of rest, and the cortical cells of the brain might be naturally expected to require longer time for recovery from stimulation and irritation than more lowly organised structures such as the cells of the salivary glands or pancreas. The disturbances of the function of sleep, like the disturbances of any other function, are dependent on some structural vice of the tissues, and the phenomena of the hypohypnotic state—dreams, somnolentia, night-terrors and so on—have, naturally, a psychical as well as an organic side. In dreams ideas and emotions succeed one another by association, but without correlation, and judgment and reasoning power are in abeyance. An idea has only to be conjured up for a train of associated ideas to follow inconsequentially on its heels, and thus we get the juxtapositions of persons and places taking place in dreams that make food for mirth when we sit down to breakfast. A nightmare, such as Mr. Haggard had, is a hypohypnotic disorder, and practically always is attributable to some more or less remote irritation; it would be interesting in his case to find out whether he was subject to nightmares, and whether he has any temporary or permanent source of irritation. That he presented some symptoms of somnolentia we should be inclined to deduce from the fact that his wife woke him up, which she was not likely to do in the middle of the night unless he was exhibiting motor phenomena of some sort. Then, too, we have the admission of the telepathists and the spiritualists that Mr. Haggard's experience of "communication" with an animal is almost if not quite unprecedented, together with the fact that the dog, if dead, must have been so for at least three hours, for it is inconceivable that a dog that had been run over by a train could live many minutes. Is there anything in the whole story that is not quite reconcilable with the simple hypothesis that Mr. Haggard had an ordinary nightmare dependent on usual causes, and that somewhere about the same time his dog happened to be killed? The admittedly unique character of the dream is in itself strong evidence of coincidence, and we think it a vast pity that fantastic superstitions should be indulged in by influential journals, superstitions that tend to put back the hands of the clock from 1900 A.D. to 1900 B.C., or earlier.

### Notes on Current Topics.

#### School Dentistry.

THERE is no disguising the fact that in matters of school hygiene and medical supervision we in this country have much to learn. THE MEDICAL PRESS AND CIRCULAR has constantly striven to enlist the interest of the profession in this topic, which is rendered doubly important now that the influence of school life and habits is being recognised as one of the most powerful

factors of the national physique. The need for the appointment of an inspecting medical officer who should preferably be attached to every Board and Council school in this country has many times been emphasised in these columns, and we offer no excuse for once more bringing the subject forward. This time, however, it is to call attention to the excellence of the arrangements adopted in several German and other Continental cities by which the teeth of school children are regularly and systematically inspected. The statistics of our own London School Board examiners have shown conclusively that bad teeth are alarmingly prevalent among the scholars of all ages and both sexes, and a similar state of affairs has been found in Darmstadt and Stuttgart. In both these towns a fully-equipped dental room has been fitted up in one or more of the central schools in which the teeth of each child are examined and appropriately treated by extraction or stopping by a duly-qualified dentist, who gives his whole time to the work. When the evils which result from the presence of carious teeth upon the digestive system, and also their liability to produce toxic symptoms, such as those of pernicious anæmia, are remembered, such measures as these are the reverse of extravagant, they are salutary in the extreme. England must not be behindhand in giving her children the benefits of modern science which can no longer be considered as luxuries but as actual necessities.

#### The Treatment of Gastropstosis.

THAT malposition of the stomach which results in a downward displacement of the whole organ is more common than is usually supposed. Meinert, of Dresden, found the condition in from 80 to 90 per cent. of all young women and girls. Deformities of the lower part of the chest, whether natural or acquired, are among the most potent causes of a falling of the stomach. Later in life, the condition may be associated with ptosis of the whole abdominal viscera, then known as Glénard's disease, in which there is supposed to be a general relaxation of the suspensory folds of peritoneum, which normally support the stomach and intestines. Movable or floating kidney may be present at the same time. A certain amount of gastric dilatation frequently accompanies its displacement, and this again is sometimes definitely connected with disorders of the nervous system. Dr. A. Rose, of New York, (a) describes cases in which migraine was associated with gastropstosis. As regards the treatment of this troublesome condition, special attention to the mode in which the gastric functions are performed is necessary, while lavage, systematically employed, may be useful in helping to overcome the accompanying dilatation. The increase in size of the abdomen and consequently in the capacity of its vessels has an important bearing upon the whole circulation, for in conditions of arterio-sclerosis there may be so much blood contained in the splanchnic reservoirs that the nutrition of the

(a) *Medical News*, July 16th, 1904.

brain may be seriously compromised. It is not enough in such cases merely to provide an abdominal belt. What is required is an actual diminution in the size of the stomach itself. Dr. Rose finds that strapping, intelligently applied over the abdomen, will, in many cases, brace up the organ, so that its true secretory functions are once more restored. In selected cases, massage over the same area might also be of service.

#### Hospitals and Post-mortems.

THE recent performance of a post-mortem examination unauthorised either by the friends of deceased or by the Coroner, has given rise to some public comment. In this particular case, a child swallowed a cherry stone and was taken to the hospital, where tracheotomy was performed. The acting house surgeon, who operated, subsequently conducted a post-mortem examination with the help of the Registrar of the hospital. At the first hearing in the Coroner's Court, he stated that it was not usual to obtain the permission of the friends to a post-mortem, an assertion that later was emphatically disproved. The reason for this belief may probably be found in the fact that some of the large hospitals make it a condition of admission that a post-mortem examination shall be made, if considered necessary, in case of death. Were it otherwise the progress of medical science would be lamentably handicapped. In poor-law infirmaries, where consent of friends is necessary, a post-mortem examination may be stopped by a person who is not even related to the deceased. In that way, the final pathological test of many obscure illnesses has been lost, and the sum of human knowledge has been the poorer. It is impossible totally to disregard sentiment even in its most unreasoning forms, especially when linked with affection, but it smacks of ingratitude when a post-mortem examination that may furnish information of value to the living is denied by the friends of a hospital patient.

#### Fatty Degeneration.

FOR many years one of the points emphasised in the differentiation of fatty infiltration and fatty degeneration was that the origin of the fat in the former case was extra-cellular and in the latter intra-cellular. This distinction was due to Virchow, who explained the formation of fat in fatty degeneration as being due to some combination of the non-albuminous constituents of the cell, splitting of the cell into albuminous and non-albuminous groups having first taken place. It is curious that, as long as this view has held the field, transcribed by one authority from another, the evidence in its favour has been so slight, while the objections to it are many and strong. On the other hand, Recklinghausen showed that both in causation and morphology fatty degeneration and fatty infiltration presented many common features, while, on the other hand, Pflüger maintained that chemically there is little basis for the assumption that fat can be formed by the aseptic

decomposition of proteid. The experiments of Rosenfeld, too, with phloridzin poisoning in dogs fed with mutton fat, showed that the fat occurring in degeneration exhibits the characteristics of the fat taken in the food, or, in other words, that the fat deposited in degeneration and in infiltration are of the same nature. In view of such facts, the current opinion among modern pathologists is somewhat adverse to Virchow's doctrine, and there is a tendency to discard the term "degeneration" as assuming a theory no longer admitted. At the same time it is to be remembered that the process is associated with degenerative changes in the cell, and, whether quite accurate or not, the distinction between "fatty infiltration" and "fatty degeneration" is still a convenient one.

#### Hadwen v. Price.

THE result of the action for libel brought by Dr. Hadwen, the Gloucester antivivisectionist, can hardly be regarded by him as encouraging. The trial arose from the remark made by the defendant medical man, Price, to the effect that a child certified by Dr. Hadwen to have died from brain fever might possibly have died from small-pox. Adverse comment of any kind from one practitioner upon the opinion of another is at any time undesirable, even when the person criticised holds views such as homeopathy and antivaccination, that have been tried in the balance of orthodox medical practice and found wanting. In this instance the person aggrieved was awarded a farthing damages by the jury, and the judge ordered that each side should pay its own costs. The actual costs paid by Dr. Hadwen are stated to have been over a hundred pounds, a sum that has been amply covered by a cheque for £154 17s. 11d. collected by Lieutenant-General Phelps, the president of the Antivaccination League, and presented to Dr. Hadwen.

#### The Risks of Professional Life.

AMONG the various risks attached to the daily life of the medical man, not the least serious is that of being attacked by a lunatic patient. Many are the experiences on record where the medical attendant has had to fight for his life with some madman, who has probably locked the door and perchance thrown the key into the fire or out of the window. Recently a startling experience of this kind fell to the lot of Dr. Shuter, of Chiswick, happily without serious results, so far as he himself was concerned. He was called to an engineer, whom he saw in his bedroom in an excited condition, and who announced the fact that he was going to blow his brains out. The man thereupon whipped out a revolver and pointed it at the doctor. The latter told him to put the weapon down, but without effect, for he immediately fired, and, missing his mark, lodged a bullet in the ceiling. An instant later he put the pistol to his forehead and blew out his brains. At the inquest the jury returned the usual verdict of suicide whilst of



unsound mind, and the Coroner complimented Dr. Shuter on his pluck. His medical brethren throughout the kingdom will warmly join in congratulating him on his escape from so terrible a jeopardy.

#### An Eventful Career.

MOST of us are familiar with the heroine of the melodramatic novelette who, at the same moment swallowed the deadly draught, discharged the revolver at her head, and plunged the fatal knife into her breast, leaped, with a wild shriek, from the dizzy height into the yawning darkness below, but "her hour was not yet." Strange as were her adventures, they were quite hum-drum compared with the career of a popular actor of the present day. Ludovic Branay, the famous Hungarian tragedian, has recently compiled statistical tables of his own stage adventures, and they are worth quoting. In his professional life he has been married 1,721 times, and suffered death 1,120 times. "I was stabbed," he says, "61 times, killed by lightning 51 times, drowned 22 times, poisoned 166 times, beaten to death 86 times, died of heart disease 192 times, assassinated 109, and executed 133 times. Finally, I committed suicide 314, and died a natural death 55 times." The list is interesting as showing the forms of death which appeal as picturesque to the theatre-going public. Yet we have seen somewhere that art should hold the mirror up to nature!

#### Lime-juice in Scurvy.

SURELY in no science is there less room for dogmatizing and appealing to canonical faith than in medicine. There is hardly an article of the medical creed that is not periodically taken up, trounced, and left to perish by the wayside, till it becomes exceedingly difficult to be certain that any real knowledge capable of being called "medicine" exists. From one's earliest days the efficacy of lime-juice in the prevention and cure of scurvy has been regarded as a point about which, however, many theories of scurvy might revolve, would still remain unmoved and immovable. Far from this being the case, from several sources lately news has been coming in that all lime-juice is not good for all scurvy, or that all lime-juice is not good for some scurvy. In which of these the truth lies it is not possible to say, for different observers speak differently. Government lime-juice is certainly not always efficacious, and both in the South African war and the Somaliland Expedition it was difficult even to get the men to drink it, so acrid and raw was its taste. And even when taken it is not always successful. In the Bengal jails there is a form of scurvy in which some patients have been freely dosed with Government lime-juice without effect, and in Somaliland similar experiences have prevailed. Fresh lime-juice certainly seems more efficacious and pleasant, but what the active ingredient is that gives it anti-scorbutic properties is not certain. A recent writer, Lieutenant Fleming Barnardo, of the Indian Medical Service,

recommends that lime-juice should be left out of the equipment of a military force, and that tabloids of citrate of potash and calcium chloride should be substituted. Undoubtedly much of the failure of lime-juice has been due to its gross adulteration. We hope this important matter may be thoroughly sifted.

#### The Hygiene of Paddling.

NOW that the seaside watering-places are daily becoming more and more frequented by holiday makers, the old question has once more arisen as to the advisability of allowing children to paddle in the sea. This is a subject upon which society papers and health journals love to dilate, and it is not surprising that many and contrary opinions thereon have been freely expressed. The practice of paddling, so dear to the child's heart, cannot be condemned wholesale, because a few cases of illness have been traced to its influence. The danger of contracting rheumatism in this manner has probably been much exaggerated. In this, as in other things, the exercise of common sense will prevent gross indiscretions. The chief dangers to guard against in paddling are cerebral congestion and chill. One of the reflex effects of cold water, especially when applied to the extremities is to produce a certain amount of congestion in the internal organs. In cases where the stability of the cerebral circulation is upset by slight causes, as in epileptic conditions, it might then be inadvisable to stand about for long periods in the wet. The direct effects of the sun's rays in very hot weather have also to be considered, and it is certainly unwise to allow young children to run about all day with no covering upon their heads, whether their feet be in the water or not. A good straw-hat or sun-bonnet will act as a sufficient screen, so that anxiety should be removed upon this point. A child who is perspiring freely should not, of course, be allowed to paddle, as it is quite easy to contract a chill in that way. Provided these simple precautions be observed, there can be no harm whatever in indulging in this particular form of amusement, which is specially associated with a visit to the sea-side. We do not, of course, refer to cases in which there is obvious organic disease present of the heart or brain, when greater care and circumspection will be needed.

#### Municipal Medical Attendance.

SWITZERLAND, the birthplace and centre of municipal life, seems determined to apply the social contract system to medical attendance. It has recently been announced that the Canton authorities have resolved to levy a new annual tax of 3s. 6d. per head, to be called the "Zurich Medical Tax." In return for that contribution the inhabitants will be entitled to free medical attendance from State-paid medical officers. There is much to be said on both sides of this new departure. So far as the public are concerned, they are likely to get more equality of practice as well as more scientific treatment, the latter

likelihood being due to the absence of any incentive on the part of the medical man to humour the fancies of his patient. Clearly it would not do for the patients to have the right of choosing their medical attendant, for in that case the popular man would be overwhelmed with work, for which he would obtain no corresponding advantage by way of emolument. After all, there is not such a very great difference between the Swiss municipal service and the British medical club service. Neither the one nor the other is likely to make any serious inroad upon the income of the medical man in high-class private or consulting practice.

#### The Progress of Sanitary Science.

THE increasing amount of interest taken in sanitary affairs generally, is shown by the large number of delegates from the home counties and foreign governments who attended the twenty-second Congress of the Sanitary Institute at Glasgow. In the course of his Presidential Address Lord Blythswood remarked that science "saved those who were a burden to themselves and a danger to others." Such, indeed, is the whole aim of medical science of which hygiene forms so large a part. If we look around at the work done by such bodies as the Sanitary Institute and the Royal Institute of Public Health, the Congress of which was held simultaneously at Folkestone, we cannot fail to see advance and improvement in every direction. The care and treatment of the consumptive, the prevention of consumption itself, the prophylaxis of infectious diseases, the health of school children, the examination into the alleged causes of physical degeneration, and the adoption or recommendation of means whereby it may be prevented when proved to exist—these are only some of the items of a gigantic, scientific programme which is gradually, though slowly, being carried out. The education of the masses in sanitary science takes time, and old prejudices cannot be overcome in a day, nor even in a generation. It is a significant fact, however, that the death-rate in Glasgow has been reduced by one-half through the introduction of sanitary measures, and this in the face of an ever-increasing population. A similar result has also taken place in the case of other large cities. With regard to the smoke nuisance, the President of the Sanitary Institute expressed the hope that the subject would be taken up in earnest during the coming session, and that the conservatism of manufacturers would not be allowed to stand in the way of a plentiful provision of pure, unadulterated air for the workers in populous centres.

#### The Dangers of Iced Drinks.

THE weakness of human nature is such that a certain amount of pleasure is always experienced in rushing to extremes. The sensation of ice-cold liquids careering down the gullet and benumbing the pharynx is so delightful in the hot weather that minor inconveniences in the shape of toothache, loss of appetite, or gastric pain are not minded. More cautious individuals try to

be a little careful both as to the nature of their frigid draughts, and also as to their place of purchase. Happily for the health of the poorer population, the introduction of more stringent by-laws respecting the ice-cream traffic, the danger of contamination of these refreshing commodities has been greatly minimised. We are not, as a rule, in the habit of consuming iced liquors the whole day long, but there is no doubt that in hot weather a considerable proportion of the cases of dyspepsia that occur owe their origin to such practices. If drunk when the system is much overheated, or weakened by over-exertion, and in large quantity, the immediate effects upon the circulation may be alarming. This fact is pretty generally known, but one or two cases in which the result of the ingestion of a large amount, suddenly, of ice-cold liquid into the stomach has been fatal may sometimes be heard of during a spell of tropical heat. There is another danger of a more insidious character, because, as a rule, unsuspected, attending the consumption of iced drinks, and that is the ice itself may contain germs of disease. Natural ice is not always free from impurities; in fact, it is frequently grossly contaminated, but that which is artificially prepared may be actually infected with pathogenic organisms. The recent occurrence of several cases of enteric fever in the Lausanne district has led the municipal authorities there to issue warnings to excursionists and others against drinking iced or snow water, or any beverages which have been mixed with ice. This is by no means an isolated instance of the danger that may lurk in an innocent-looking lump of ice.

#### Phosphoric Acid in Gastric Medication.

IN the many different clinical types of dyspepsia it is often a matter of no small difficulty to select a remedy that will not only relieve subjective symptoms, but will also enable the gastric juice to act with the greatest efficiency. Sometimes it is alkalies, and at other times acids which bring about the desired result, or it may be necessary to combine one of these with some preparation of pepsin itself. In states of hyperchlorhydria the administration of acids is obviously not called for, but, unless a chemical examination of the gastric contents be made, it is not always easy to detect the minor degrees of hyperacidity. It is a significant fact that the gastric juice normally contains acid, and that a mineral one, and it is probably for this reason that the dilute nitrohydrochloric acid has long been a favourite ingredient of many so-called indigestion mixtures. When an acid is given internally, it acts to some extent as an antiseptic, it excites the flow of the normal digestive juices, and it assists the action of the stomach ferments. M. A. Martinet (a) finds that phosphoric acid is in many ways preferable to the dilute nitric or hydrochloric acids. In the first place it is a less powerful acid, and it

(a) *La Presse Med.*, July 23rd, 1904.

is neutralised in the intestines with the formation of sodium phosphate. It is not irritating to the delicate renal epithelium, and by the kidney it is eliminated as the acid sodium phosphate, the salt to which the normal acidity of urine is due. The ordinary mineral acids sometimes cause irritability of the stomach, which phosphoric acid is said not to do, while it is also credited with certain tonic effects upon the nervous system. This latter function is not improbable, when we consider the rôle played by phosphorus itself in the nutrition of nervous tissue.

#### Bathing During Menstruation.

A CARDINAL maxim of all gynecologists is that no risk of a chill should be incurred by women during the menstrual period, and in connection with this a very widespread tradition has sprung up that the daily bath should be given up whilst the monthly flow continues. Dr. Clifton Edgar, of New York, has lately circularised the leading gynecologists as to their views on the matter, and has classified their replies. The general consensus of opinion seemed to be that bathing was largely a matter of habit, and could be practised by its devotees with impunity during menstruation, but that this did not hold with all women, and in any case sea-bathing should certainly be eschewed. The daily tepid sponge bath (85° to 92° F.) should be encouraged, for besides being innocuous, it was demanded by the rules of hygiene. If omitted on the first day, practically all women could take such a tepid bath on the second or third day after the flow was established, and, finally, that in most women the habit of taking a tepid shower or sponge-bath could and should be acquired. With these opinions we generally concur, for they are eminently sane and rational, and it is a pity that so necessary an adjunct to cleanliness at the time when it is most needed should be omitted through a mistaken notion of its harmfulness.

#### The Danger of Public-Houses.

It has long been known, and the insurance offices have noted the fact in a practical fashion, that the public-house trade is an unhealthy one for the employés. The great danger naturally is that of alcoholism, but in the wake of alcoholism comes tuberculosis, and the mortality of people engaged on licensed premises from tuberculous disease of the lungs has always been high. Dr. Allen, Medical Officer of Health for Westminster, in his last annual report, points out the mechanism by means of which the connection between the two is probably effected. Persons disabled by consumption from pursuing their occupation turn naturally to the public-house to while away the day, and, as is the habit with public-house *habitués*, spit freely on the floor. In one public-house in which the consumption rate was especially high, Dr. Allen took specimens of the expectorated matters on the floor of the bar, and had them

stained for tubercle bacilli. The bacteriologist reported that the organisms were present and in an active condition. Now, it is no difficult matter to understand how in a hot, stuffy, ill-ventilated public-house, whose bar is thronged with goers and comers all day and half the night, expectorated matters become dried and pulverised. Converted into dust, they are freely inhaled by those whose constitutions are apt to be impaired by the close air and indulgence in alcohol, so that the conditions for breeding tubercle could not be more favourable. Dr. Allen suggests that some adequate disinfectant should be used to moisten the floor of the bar, so that the dust, with its bacilli should be kept from rising, and the organisms themselves gradually killed. This plan may modify the evil, but so long as people persist in frequenting premises where every condition is adverse to health, so long will they render themselves liable to the inevitable consequences.

#### Prevention of Perineal Rupture.

ONE of the boasts of the present age, and especially of the present moment when health congresses and sanitary banquets are in full swing, is that preventive medicine is making unprecedented strides, and that disease and death are being kept at arm's length through the science of hygiene. But a perusal of trans-Atlantic literature casts somewhat of a blight over the rising spirits of the enthusiast, for it impresses him with the saddening reflection that he is but a babe in these matters, whilst his fellow Anglo-Saxon scientist is forging ahead. Let him, if he doubt this, glance at the proceedings of the annual meeting of the American Gynecological Society in May last, and he will find how far he is from reaching the pitch of anticipation in obstetrical science that has been there attained. Dr. Laphorn Smitt, of Montreal, spoke of the importance of perineal ruptures during parturition, and showed how even small tears are liable to become the seats of septic infection and absorption. Besides this immediate danger, large tears involved the probability of prolapse of the pelvic organs from weakening of the support normally maintained by the flow. If ruptures occurred, they should be sutured at once, but far better than waiting till the tear occurred, was to anticipate it. This might be best accomplished by putting in the stitches before the head passed the perinæum, whilst the patient was anaesthetised, and the parts in their proper positions. Two or three sutures having been inserted, they should be caught loosely in Peau forceps, until the placenta was delivered, and then quickly tied so that the apposition of the edges might be as accurate as possible. Dr. Laphorn Smitt evidently takes a gloomy view of his skill in preventing rupture. We wonder what he says to the patient whose perinæum remains intact, and who finds sutures and forceps fastened thereto after the completion of labour. The situation must be a rather delicate one.

## PERSONAL.

THE King has been graciously pleased to confer the decoration of the Royal Red Cross upon Miss J. Bradbury, Miss C. Addison, Miss S. Ruiter, Miss E. M. Early, in recognition of the services rendered by them in tending the sick and wounded at the Volunteer Hospital, at Intombi, during the late war in South Africa.

THE Marquis of Ripon, K.G., President of the Western Ophthalmic Hospital, Marylebone, London, recently opened a new out-patient department, which has been added to that institution at a cost of £3,800.

DR. W. H. SYMONS, the well-known medical officer of Bath, has presented a local institution with an excellent geological model of Bath and surrounding district.

MR. JOHN F. SYDNEY COLOHAN, of Blackrock, has been appointed a Justice of the Peace for the County of Dublin, on the recommendation of the Right Hon. the Earl of Meath.

ON the 24th ultimo, Dr. John Keys, of Dublin, was presented with a handsome testimonial of silver plate and other valuable articles on the occasion of his recent marriage.

THE Earl of Radnor, in his presidential address at the Folkestone meeting of the Royal Institute of Public Health, dwelt chiefly on the necessity of better sanitation of country in its relation to town supplies.

MR. ALFRED WILLETT will be presented with a gold medal in recognition of his long and valuable services to St. Bartholomew's Hospital, and a silver "Willett" medal will be awarded annually to the candidate attaining highest marks in the Brackenbury Surgical Scholarship.

DR. H. G. HAYMAN, delivered a most interesting address as President of the annual meeting of the Western Counties Branch of the British Dental Association, held last week at Frome.

DR. G. POČOCK GOLDSMITH, of Bedford, was entertained at dinner last week by his fellow medical practitioners on the occasion of his retirement from practice. For thirty years Dr. Goldsmith was actively engaged as surgeon on the staff of the Bedford Infirmary, and was afterwards appointed consultant surgeon.

SIR MICHAEL HICKS-BEACH recently opened a large and handsome home for the nurses of the County Infirmary at Gloucester, and delivered a most interesting speech upon that occasion.

DR. ERNEST CLARKE, Chandos Street, Cavendish Square, London, while passing through Walton last week on a motor-car, was struck on the neck by a shot apparently from a gun, but no trace of the offender can be found. Dr. Clarke, fortunately, was not seriously hurt.

THE Middlemore triennial prize for the best thesis on ophthalmology was presented in the Shelbourne Theatre at Oxford, at the inaugural reception of the British Medical Association, to Mr. John Herbert Parsons, M.B., B.S., F.R.C.S.

DR. THOMAS A. DOWSE has been appointed Government Medical Officer at Levuka, Fiji, and Dr. Charles E. Maguire, District Medical Officer of Suva.

SIR THOMAS BARLOW, M.D., and Dr. A. D. Waller have been appointed representatives of the University of London at the International Congress of Medicine to be held at Lisbon in April, 1906.

MR. A. B. KEMPE, Secretary of the Royal Society, represented that body at the funeral of the late Sir John Simon, on Wednesday last.

## Correspondence.

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

## THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Drysdale writes:—"Economically, it is out of the question for the people of any European State like ours to think of having large families with impunity." It would be very interesting if he would attempt to establish the truth of this statement by an examination of the economical position of France in relation to the population question—France, whose people have carried to a logical conclusion the ideas developed by Dr. Drysdale and his school. France, with the most fertile soil—a soil capable of sustaining many more millions than at present subsist upon it—the most magnificent climate, and the most intelligent populace of Europe, has not enough men for her home requirements. Her numbers are kept up only by immigration of Italians, Swiss, and Germans. She cannot spare, and virtually she does not send, any emigrants to occupy and develop the vast possessions misnamed Colonies—even to beautiful Algeria close to her shores—which she has acquired mostly within a few years; so that to the onlooker these seem but a useless burden, expense, and source of weakness to the State. It cannot be doubted that these territories will in time either by peaceful or warlike conquest be overrun and acquired by stronger and more prolific races, white or yellow. France is already one-third less in population than Germany, and the disparity will soon be much greater, so that the resumption of her once dominant position in Europe seems for ever hopeless. Besides limiting the population, the French are, in fact, carrying out a gigantic system of artificial selection which, whilst ensuring the survival of the first born and their progeny, ensures at the same time, to a large extent, survival of the comparatively unfit. It is not prudence alone which guides the modern French parent, but the narrowest form of anti-social egoism, the egoism which sacrifices everything in pursuit of ease and pleasure, and regards toil and self-sacrifice as the sources merely of pain and unhappiness. The population question in later generations has become invested with a meaning very different from what it expressed to the old political economists like Malthus, to whom Dr. Drysdale refers. With these islands getting their food supply from the remotest parts of the globe, and with those supplies inexhaustible, with Canada, Australasia, Africa, and other vast colonies crying out for population, and able to sustain countless millions, there should be for many a long year no useless surplus of men and women in Britain. Instead of attempting to limit population, statesmen and practical sociologists should rather direct their efforts towards removal of social diseases which keep so large a part of our people physically, mentally, and morally inferior. Our surplus population is composed of these inferior classes, mostly a burden upon the State, far below the standard fit for emigration to the rich lands beyond the seas where, among kith and kin, comfort or wealth awaits the efforts of every competent citizen.

I am, Sir, yours truly,

July 26th, 1904. A STUDENT OF SOCIOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It seems to me that both Dr. Taylor and "A Student of Sociology" have hardly appreciated the point of Dr. Walsh's admirable paper on "The Diminishing Birth-Rate." Dr. Walsh does not deny that a portion of the loss in births is due to the practice of methods that are admittedly artificial, nor does he advocate their employment as Dr. Drysdale does in your issue of the 20th inst. In their dislike of these practices Dr. Taylor and "A Student of Sociology" will have many sympathisers, but that is not the issue. The question is—Are artificial methods for preventing conception the cause of much modern crime, lunacy, and suicide, or are these methods a symptom of the same disease of the body politic as that which gives

rise to those other deplorable manifestations? Dr. Walsh's paper is irrefutable on this point. If artificial methods are the root cause of all this misery, I would put it to his critics that if one takes away that cause, the consequences disappear. Will they affirm that if every married couple in this England fell to producing as many children as time and opportunity gave them occasion, our gaols would empty, our lunatic asylums be converted into country houses, and *felo de se* be unheard of in the land? I have only to submit the issue in this form to show how untenable their position is. Dr. Walsh rightly deprecates sensational, alarmist statements and hasty generalisations, and pleads for a philosophic review of the situation. Let us admit that we are more likely to arrive at the truth by the latter method, and that, however much we may detest a particular symptom of a disease, it is not by attacking it that we shall cure the patient. The treatment must be specific and must be adapted to the sufferer; not symptomatic and arbitrary. We must in this matter weigh things in their due proportions, and not be like Gribouille, *qui se jette dans l'eau de peur de la pluie*.

I am, Sir, yours truly,

July 28th, 1904.

QUID PLURA.

#### MEDICAL MEN AND DRINK LEGISLATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your annotation on this question you ask, "Why should not medical men speak out their collective mind as to whether Mr. Balfour's alterations in licensing law are likely to increase the facilities for drinking amongst our countrymen." Having taken great interest in this question, I shall be glad if I may for one answer.

In the first place there can be no doubt the teetotal section is responsible for taking the initiative in setting the law in motion in lieu of following Shakespeare's advice to allow sleeping dogs to lie. And the initiative consisted in the high-handed conduct of certain (I presume) bigoted magistrates in depriving publicans of their licences without means or compensation and for no fault of their own. It is inevitable that in a procedure of this kind public opinion would demand a change of law. On the other hand had the teetotalers trusted to the gradual reduction and minimising effects of public houses and depended on the simple method of refusing new licences, except in urgent cases, although this method might require more patience and be less drastic, the law would then have remained quiescent. It follows, therefore, if the remedy offered by the new Act should eventually turn out (*Tempus omnia revelat*) unsatisfactory the teetotalers have themselves only to blame—their chief aim appears to consist in straining every nerve to embarrass the trade and inconvenience the public to the utmost, charging them with what they conceive to be an overstepping of the mark, and getting more than they bargained for; hence, with the aid of the Bishops who fire off their guns blindfold, they have attempted to wreck the measure by insisting on a time limit.

Now it is certain this time limit must result in one of two things. Either the licensing authorities would cease to reduce licences, there being no compensation to meet the difficulty—in which case the Act must become a dead letter—or if they did reduce without compensation, in response to the clamour of the teetotal section, only the most God-forsaken and demoralised specimens of humanity, who would not shed a tear if a licence were granted one hour and taken away the next, would occupy the throne. The question, therefore, is melted down, according to my view, to the choice of one of two alternatives—either the acceptance in future of Mr. Balfour's respectable publicans' measure without a time limit or the Bishops' unfair scheme with. I venture to predict the vast majority of medical men would prefer the former, and hence vote in favour of the new Act.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, July 22nd, 1904.

#### SOME OF THE NEWER METHODS OF OPENING AND CLOSING THE ABDOMEN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In this week's issue of your journal Dr. Alexander Duke writes that the method described by me for closing the skin wound in abdominal sections is in reality that employed by Professor Bozemann many years ago, to whom the credit for its introduction is due.

I am obliged to Dr. Alexander Duke for information as to the inventor of surgical leaden plates. I have known of them since my student days, and they have been conspicuous objects in all instrument makers' establishments for years.

These so-called Bozemann plates are placed at intervals across a wound, and are intended for the application of interrupted sutures; while the plate described by me extends the entire length of the wound, and serves as a means for tightly fastening a sub-cuticular suture. To Sir Kendal Franks is due the credit of applying the latter form of suture to surgery, and it certainly was not known at the time of the first appearance of the leaden plates, nor would it be possible to employ these with the sub-cuticular suture. Under these circumstances it seems needless to discuss the subject further.

Dr. Alexander Duke has betrayed amazement at my statement that silk-worm gut is capable of remaining for fourteen days in a wound without cutting out or exciting inflammatory reaction.

To me it is a matter of wonder that in spite of the many excellent post-graduate courses now obtainable a practitioner can be found so little conversant with the elementary result of modern aseptic surgery.

I remain, Sir, yours truly,

E. HASTINGS TWEEDY,

Master, Rotunda Hospital.

Rotunda Hospital, Dublin.

July 29th, 1904.

### British Medical Association.

SEVENTY-SECOND ANNUAL MEETING.  
OXFORD, 1904.

[SECOND ARTICLE.]

[BY OUR SPECIAL MEDICAL REPORTER.]

THE Oxford Meeting has proved a conspicuous success. Upwards of two thousand members and delegates have attended. Visitors came from all parts of the Empire, and many distinguished guests from afar. The weather, it is true, has damped much of the festive proceedings, but both gown and town extended an open-handed hospitality to the Association. The University threw open wide its doors, the President was indefatigable in the conduct of his onerous duties, local members of the profession were loyal and untiring, residents have assisted in many ways, the Press has admirably reported the proceedings, the scientific work of the sections has been good, the pathological museum excellent, and the exhibition of medical material thoroughly satisfactory. Altogether the gathering has proved of exceptional interest, and all concerned in the success of both professional proceedings and social functions may well be congratulated.

OXFORD—THE CITY AND UNIVERSITY.

This ancient seat of learning is truly a garden city of delight. Oxford is rich in all that makes for the joy of life. It offers unique attractions for all sorts and conditions of men. Countless objects of interest are ever at hand and the environment is one which peculiarly appeals to the student of human affairs. The University has offered all possible facilities to its medical visitors. The Examination Schools, the University Museum, and the Sheldonian Theatre have all been placed at the disposal of the Association. Many

of the Colleges with their chapels and halls and time-worn courts and venerable gardens, were thrown open. The Municipal Buildings have also been available. Every member of the Association was furnished with a copy of the special edition of Alden's admirable Oxford Guide, which, with its key-plan of the University and city proved invaluable to strangers.

#### SPECIAL ASSEMBLIES.

The official programme was from Tuesday, July 26th, to Friday, July 30th, but not a few visitors extended their visit by additions at both ends. A special service was held in Christ Church Cathedral on Tuesday morning, when the Master of University College, the Rev. J. Franck Bright, D.D., son of the famous Guy's Hospital physician, preached from St. John's Gospel v., 17, "My Father worketh hitherto and I work." A special Mass was also said at the Church of St. Aloysius. Religious services were held on Wednesday morning at Mansfield College Chapel and at Manchester College Chapel.

A large and brilliant gathering assembled in the Sheldonian Theatre on the evening of the 26th to hear the Presidential address and to witness the reception of distinguished guests. Dr. Collier delivered an appropriate and interesting address on "The Growth and Development of the Oxford Medical School."

On Wednesday, the 27th, the Conferment of honorary degrees attracted much interest. The degree of D.Sc. *honoris causa*, was conferred on Professor Clifford Allbutt, Mr. Andrew Clark, Dr. F. D. Griffiths, Mr. Jonathan Hutchinson, Sir William MacEwen, Sir Patrick Manson, Sir John William Moore, and Professor William Osler.

The Address in Medicine was delivered by Sir William Selby Church, who dealt with sanitation, particularly in reference to national health. The Address in Surgery was given by Sir William MacEwen, who treated of cerebral invasion by pathogenic and pyogenic organisms and other matters connected with surgical technique.

A desirable innovation was furnished in the popular lecture illustrated by some ninety lantern slides, given in the Town Hall on Thursday evening by Dr. G. Bagot Ferguson, who, in an attractive manner, presented the more important points relating to "disease germs" to the large and appreciative audience.

The annual medical temperance breakfast which this year received due recognition on the official programme of the Association, was held on Thursday morning in the Assembly Room of the Town Hall, and was largely attended. Mr. McAdam Eccles presided, and was supported by many influential members. The President of the Association spoke, and Dr. T. N. Kelynack gave an address on "The Medical Aspect of Alcoholism."

#### THE GENERAL AND REPRESENTATIVE MEETINGS.

Under the new *regime*, the purely business part of the Association is localised and concentrated, and its conduct, under the able chairmanship of Sir Victor Horsley, is greatly facilitated. The details of the work accomplished are duly published in the Official Journal, and much time and temper is saved by the new method of procedure, and we believe the usefulness and dignity of the Association is hardly likely to suffer by the incoming of the new dispensation. The question of medical defence gave rise to much discussion, and the matter is to be thoroughly investigated during the year. Hospital reform and contract practice also received consideration.

#### THE WORK OF THE SECTIONS.

The real scientific work of the meeting was conducted in fifteen separate sections, the majority of which found excellent quarters in the splendid and in every way convenient University Museum Buildings. The attendance was generally good. Much interest was taken in the various set discussions, which, although far from epoch making, were nevertheless usually helpful and suggestive and characterised by a sound practical directness. Many of the papers presented were of considerable value. The more important subjects dealt with we hope to summarise in our pages.

#### SECTION OF MEDICINE.

A discussion on the "Treatment of Chronic Interstitial Nephritis," introduced by Dr. W. Hale White, a full abstract of whose paper will be found in another column, aroused much interest. Albuminuria was considered of insignificant importance, but cardio-vascular conditions needed much management. Professor von Noordan advised the employment of well-regulated exercise, deprecated the excessive use of fluids, and would not withhold a meat diet. Professor Osler's opening paper to the discussion on "Tuberculous Pleurisy and Pneumothorax" admirably summarised the best modern views of dealing with these conditions. A discussion on the "Serum Treatment of Disease" was opened by Dr. E. Goodall. Many papers of value were presented, including those by Drs. Mackenzie and Nicholson, on the "Maternal Heart in Pregnancy," Dr. Gibson on "Bradycardia," and Mr. Hastings Gilford on "Ateleiosis." Some of the communications were illustrated by lantern slides. The attendance at this section was very good.

#### SECTION OF SURGERY.

The question of "Asepsis and Antisepsis," introduced by Mr. F. F. Burghard, afforded useful opportunity for the comparison of present day methods of surgical technique. The discussion on "Hysterectomy Retroperitoneal Tumours and Cervical Fibroids" attracted many gynaecologists. A number of papers were also presented.

#### SECTION OF OBSTETRICS AND GYNÆCOLOGY.

Sir Arthur Macan opened the first day's discussion on the "Treatment of Accidental Hæmorrhage." Dr. Herman and many others also contributed to the "Study of the So-Called Ovarian Pains." A number of papers of gynaecological interest were also presented.

#### SECTION OF STATE MEDICINE.

Here many matters concerned with personal and public hygiene were discussed. Dr. J. S. Haldane dealt with "Standards of Ventilation." "Poverty and Public Health" were ably presented by Mrs. Bosanquet, Mr. T. P. Whittaker, M.P., and Alderman Hugh Hall. The co-operation of laymen offers a procedure which merits much approbation.

#### SECTION OF PSYCHOLOGICAL MEDICINE.

Dr. Charles A. Mercier in his presidential address reviewed the subject of "Criminal Responsibility and Degeneracy." The discussion on "Heredity in its Biological and Psychiatric Aspects" gave rise to much of interest, and the contributions of Dr. J. Beard and Dr. W. König were listened to with much attention. Dr. Conolly Norman opened a discussion on "Dementia Præcox."

#### SECTION OF PATHOLOGY.

Dr. James Ritchie, the President of the Section, concisely presented the various views promulgated as to "Immunity," and several papers dealing with the subject were read. Professor von Noordan opened a discussion on the "Chemical Pathology of Gout," and Dr. Lovell Gulland and Professor Muir dealt with the "Physiological and Pathological role of the Lymphocyte."

#### SECTION OF OPHTHALMOLOGY.

The meetings of this section were held in Keble College. The President, Mr. Marcus Gunn, opened this discussion on "Retro-Ocular Neuritis." "Intra-Ocular Hæmorrhage and Systemic Disease," and "Keratitis Profunda," were also subjects which gave rise to considerable discussion.

#### SECTION OF LARYNGOLOGY AND OTOTOLOGY.

Dr. Urban Pritchard dealt with the ever interesting matter of the "Treatment of Non-Suppurative Diseases of the Middle Ear." The etiology, treatment, and prognosis of innocent growths of the larynx and intra-nasal disease as a determining factor in the production of laryngeal and pulmonary affections offered much fruitful matter for discussion. A considerable number of papers were also presented.

#### SECTION OF NAVY, ARMY AND AMBULANCE.

Many questions of Imperial interest were dealt with,



including the "Sanitation of Camps," "Malta Fever," "Mediterranean Fever," "The Medical Equipment and Transport for Volunteer Brigades."

#### SECTION OF TROPICAL DISEASES.

The more important subjects considered include "Trypanosomiasis," "The Prophylaxis of Malaria," and "The Significance of the Leishman-Donovan Bodies." A number of papers dealing with various tropical diseases were also read.

#### SECTIONS OF ANATOMY AND PHYSIOLOGY.

These sections appealed chiefly to teachers in our medical schools. Important discussion took place on the "Thalamic Region," "Chloroform Anæsthesia," and "Giants and Dwarfs."

#### SECTION OF DERMATOLOGY.

Discussion took place on Pruritus Ani; the Comparative value of old and new methods of treating lupus and other skin diseases, and the relative importance of the bacterial and other factors in the causation of skin diseases.

#### SECTION OF DENTAL SURGERY.

A discussion on oral sepsis attracted considerable interest, and numerous physicians and surgeons took part.

#### THE PATHOLOGICAL MUSEUM.

Special efforts had been made to secure a thoroughly representative collection which should illustrate the best results of recent investigations, and Dr. James Ritchie and Dr. E. W. Ainley Walker and their Committee may well be congratulated on the high standard of excellence attained. The carefully-prepared catalogue of 80 pages gave particulars of 1,028 exhibits. The Anatomical Department of the University Museum afforded admirable quarters, and the display of specimens and drawings allowed of ready and convenient inspection. The collection is undoubtedly the best for many years past, and it is to be regretted that it has to be dissipated so speedily.

The products of photography occupied much space. Many photo-micrographs were on view, and the results of colour photography attracted much attention. Stereoscopic work was well represented, and there was also a large collection of radiographs.

There were many excellent drawings illustrating dermatological and other clinical cases.

Among the numerous specimens special attention deserves to be called to the preparations illustrating the most recent work connected with the pathology of new growths; the causation of so-called "sleeping sickness," and various neurological studies.

The "pickles" were of considerable importance, especially the collection of preparations illustrating the morbid conditions affecting the vermiform appendix; the surgical treatment of gastro-intestinal lesions; and the pathology of the prostate.

Many specimens of exceptional importance were found in the section of obstetrics and gynaecology. The collection of preparations illustrating laryngology and otology was somewhat meagre. A feature of real value was that which dealt with apparatus and methods. The arrangement by which workers were enabled to actually describe and explain their methods in afternoon demonstrations is to be highly commended.

An excellent collection of ophthalmological specimens was open to inspection at Keble College.

The University Herbarium situated at the Botanic Gardens was also open to members.

#### THE EXHIBITION.

We can well imagine the horror which certain dons of the University would have experienced could they have seen their magnificent Examination Schools given over to the purposes of a trade show and invaded by meat extracts, infants' foods, mineral waters, and the like. This year's Exhibition, however, has been well arranged and extensively visited, its location in the same building as the reception room making it particularly convenient of access. The arrangements have been entirely in the hands of the headquarters staff, and, generally speaking, the arrangements were judicious.

The catalogue formed a bulky volume of 220 pages, and there were 116 exhibitors. Drugs and new

synthetic preparations were not so conspicuous as usual. Surgical instruments and appliances were present in great abundance. There was also a fair show of sanitary appliances. Foods and food products were extensively represented, and many exhibitors of mineral waters and beverages had been found a place. A few publishers of medical works had stalls, but some of the largest and most important houses were conspicuous by their absence.

We propose next week to deal with some of the more important exhibits.

#### THE ENTERTAINMENTS.

The purely festive features of the Oxford meeting have been notable. The unsettled nature of the weather added much to the perplexities of management, but throughout the arrangements for the comfort and enjoyment of the visitors were excellent. On Wednesday afternoon the President and members of the Oxford division gave a reception in the charming Wadham College gardens; and at the same time a duelling and fencing exhibition, with epee contest between Oxford and Cambridge, was held in the Town Hall. In the evening a largely attended soirée at the Museum was given by the Vice-Chancellor and members of the University, at which there were many attractive exhibits and scientific demonstrations.

On Thursday garden parties were given by Dr. and Mrs. Neil at the Warneford Asylum, and Mr. and Mrs. G. H. Morrell at Headington.

The annual dinner was held in the ancient and famous great hall of Christ Church; and on the same evening a particularly delightful reception was held by the Ladies' Committee in the New College Gardens and Hall.

On Friday the Duke of Marlborough gave a garden party at Blenheim Palace, and in the evening the Mayor of Oxford (Dr. E. A. Bevers) held a reception in the city buildings.

During the week promenade concerts were given in the gardens of St. John's College and Worcester College.

Many visitors availed themselves of numerous opportunities for river excursions, visits to the Clarendon Press, inspection of the various colleges and many other buildings of interest in Oxford.

Excellent arrangements were made for visitors. Many resided in the colleges. The Reception Room was well managed, and comfortable reading, writing, and smoking rooms were provided. Special rooms were available for ladies.

#### THE EXCURSIONS.

The picnic aspect of the meeting cannot be neglected. Many practitioners are obliged to make the yearly gathering an important part of their annual holiday, and it is well that the purely pleasurable side should not be allowed to suffer neglect.

On Saturday a large party visited Leamington, and later attended a garden party given by the Countess of Warwick. Others took part in a river excursion to Reading and Henley, while not a few continued their rambles about the quiet courts and quaint College precincts of this ancient seat of learning.

#### MISCELLANEOUS.

The Oxford Meeting has been characterised by a delightful combination of utility and festivity, professional industry and social enjoyment. The combination of ancient environment and modern methods has heightened the interest of the gathering. Even in the entertainments science has not been ousted. At the Vice-Chancellor's *Conversazione* many exhibits of high value attracted attention especially the performances of the mice bred by Mr. A. D. Darbishire, by crossing a race of Japanese "waltzing" mice with ordinary European albinos, and illustrating the failure of "Mendel's Laws."

The enterprising firm of Burroughs Wellcome and Company issued to members a dainty little pocket manual, "Oxford Medical Lore," which contained much information of historical interest.

Various important meetings were held during the week, and served to rally those members interested in the work of the New Sydenham Society, the Irish



Medical Schools' and Graduates' Association, the Continental Anglo-American Medical Society, and the United Kingdom Police Surgeons' Association.

Next year's meeting of the Association is to be held at Leicester, the President-Elect being Mr. George Cooper Franklin, F.R.C.S., Surgeon to the Leicester Infirmary.

### Obituary.

HUGH WILLIAMS, L.R.C.S. & P.ED., LIVERPOOL.

THE death took place on the 26th ult., at his residence in Liverpool, of Mr. Hugh Williams, one of the best-known men in Everton. Deceased, who was 59 years of age, had spent practically all his life in this city, and for many years carried on a large practice. He was extremely popular among the poor, to whom he always showed a generous disposition. Although taking no prominent part in public affairs, the deceased was keenly alive to all that was taking place around him. Some time ago Dr. Williams proceeded to Egypt for the benefit of his health, which showed signs of breaking up. He did not, however, overcome the disease from which he was suffering. Deceased leaves a widow and several children. His professional education was conducted at the Liverpool Medical School. In 1878 he qualified as Licentiate of the Royal Colleges of Physicians and Surgeons at Edinburgh.

FREDERICK FLINT, M.D.ABER., M.R.C.S.ENG. SCARBOROUGH.

We regret to announce the death, on the 25th ult., at Kirbymoorside, of Dr. Frederick Flint, of Scarborough. Dr. Flint had been ailing for some time past, and on the advice of Sir Thomas Barlow took up his residence at Kirbymoorside some three weeks ago. The deceased gentleman, who was in large practice at Scarborough, was 62 years of age, and leaves a widow, three sons and six daughters. He had practised in Scarborough for the past thirty years—during the last seventeen years of that period in conjunction with Dr. Ross. For a number of years he was senior deacon at Bar Congregational Church. He has left a wide circle of friends to mourn his loss. Dr. Flint was educated at King's College, London, whence he took the M.R.C.S.Eng. in 1866. In 1870, he graduated M.D. at Aberdeen University.

JOHN JOSEPH CRANNY, M.A., M.D., F.R.C.S.I.

WE regret to announce the death of Dr. John Joseph Cranny, of 17, Merrion Square, on the 27th of July, at the age of 59. He was one of the best known and most popular as well as the most scientific medical men in Dublin. Apart from his professional reputation, he was widely known as a benevolent and philanthropic man, although of so modest a disposition that the origin of many of his benefactions remained unknown. He took his B.A. degree in the University of Dublin in 1869, together with the degree of Bachelor of Medicine. He then practised at the Rotunda Hospital; took his Fellowship at the Royal College of Surgeons in 1870, and his degree of medical doctor in Trinity College in 1872. Since that time he had been amongst the leaders of his profession in Dublin. He was one of the surgeons attached to Jervis Street Hospital, an Examiner in Midwifery of the College of Surgeons, an Assistant Physician of the Rotunda Hospital, a Fellow of the Royal Academy of Medicine, a member of the British Medical Association, of the Royal Dublin Society, and the Royal Irish Academy. His culture however, was of a versatile type that extended far beyond the confines of his own profession. Among his contributions to medical literature may be mentioned "On Polypus of Uterus and use of Sea Tangle Tents," and "Obstruction of Bowels successfully treated by Laparotomy," published in the *Dublin Journal of Medical Science* in 1889.

D. F. B. REARDON, L.R.C.P.I. AND L.M., OF BRUFF.

WITH much regret we announce the death of Dr. D. F. B. Reardon, of the Hermitage, Bruff, which

took place, after a short illness, at the Whitworth Hospital, Dublin, at the early age of 45 years, and in the 22nd year of a distinguished medical career. His early and unexpected demise has caused intense grief to his afflicted family as well as to a large circle of friends. Dr. Reardon had endeared himself to all who knew him by his straightforward principles, kindness, and sympathetic disposition, especially towards the poor, who have every reason to mourn his loss. He was a long standing subscriber and supporter of THE MEDICAL PRESS AND CIRCULAR. His medical education was conducted at the Royal College of Surgeons, and Ledwick School, Dublin, whence in 1880 he took the qualification of L.R.C.S.I.

### Literature.

THE TRYPANOSOMIASIS EXPEDITION TO SENEGAMBIA. (a)

THIS monograph is a credit alike to English scientific work in general, to the Liverpool School of Tropical Medicine in particular, as well as to Drs. Dutton and Todd, its authors. The stay-at-home reviewer, whose opportunities for observing trypanosomiasis are a negligible quantity, may be pardoned if, unlike arm-chair strategists, he abstains from criticism of a piece of work bristling with new and interesting facts, and tries merely to give a brief general summary of the author's results. Trypanosomes, then, were found in man, horses, rats, mice, tortoises, snakes, and frogs; this report contains a great deal (and the promise of more) about the first two of these forms, and a shorter account of the others. Section I. deals with laboratory methods, and here we must thank the authors for having taken the trouble to define the meanings of the various names of leucocytes used in their differential counts, for almost nothing (and we speak from a not inconsiderable experience of the literature of blood diseases) is a greater source of confusion than the vague way in which the terms "lymphocyte" and "mononuclear leucocyte" are used by different writers; this the authors have realised, and their work is in consequence the freer from ambiguity. Section II. deals with the human trypanosome, which was found in six out of 1,043 natives examined (a number probably below the real frequency). No evidence was found that infection was favoured by any particular type of locality. A clinical description of two European and six native cases is given, from which it would seem that the disease is so mild as readily to escape notice. Besides the parasite, the blood shows eosinophilia and increase of mast-cells and mononuclears, the last containing deep lake-coloured granules when stained by a modification of Romanowsky's method. In Section III. the equine form of the disease is described, the horse being the only animal in which a pathogenic trypanosome has been found; it was found in ten out of thirty-six animals. The disease is chronic, occurs generally throughout the Colony, and is possibly more prevalent near the river, especially in the rainy season. The morphology of the human and equine trypanosome is described in Section IV, and in Section V. are given the details of a series of attempts to transmit the disease to rats and mice by tsetse-flies. In this the authors were unsuccessful, possibly because the excessive lack of moisture in the air (in the dry season) prevented the trypanosomes from living on the proboscis of the tsetse-fly. From the results of inoculation of mice and rats the writers believe that human and equine trypanosomiasis are different diseases. The last section gives a description of the species of flagellata met with in other animals. The report is fully illustrated with maps, charts, photographs and coloured plates, for all of which, especially the last, the publishers deserve much praise. A second report, treating of the more purely pathological aspects of trypanosomiasis, is promised.

(a) "First Report of the Trypanosomiasis Expedition to Senegambia (1902)." By J. Everett Dutton, M.B., and John L. Todd, M.D., Liverpool School of Tropical Medicine. Memoir XI. London: Longmans, Green and Co. 1903. 4to, pp. 57.

## THOMSON'S MANUAL OF SURGERY (a)

IN the preparation of this work, the authors, as stated in the preface, have endeavoured to furnish a systematic view of the present-day aspects of surgery in sufficient detail to render it useful to the practitioner, without at the same time carrying it beyond the scope appropriate to a manual for students. They have curtailed as far as possible theoretical and debatable matter, and have only described pathological processes in so far as they bear directly on diagnosis and treatment.

Chapter II., dealing with conditions which interfere with repair, gives some very instructive temperature charts illustrating the various ways surgical cases "go wrong." In the treatment of burns the authors find the application of a watery solution of picric acid most satisfactory, it yields the best results in the more superficial burns, but is useful as a primary dressing in all. The treatment recommended for shock does not correspond with recent work on the subject, for strychnine is recommended as the best of all.

The chapters devoted to the injuries of bones and joints are very good. With regard to fractures of the internal condyle of the humerus, the authors say: "It is sometimes necessary to fix the small fragment in position by a nail inserted through the skin." This seems to us to be a barbarous method of treating such an injury, for the risks are equal to those of an open operation without the advantages of the latter. A similar procedure is recommended in some cases of T-shaped fracture of the same bone, and in fractures through the neck of the femur. We are glad to see Bennett's fracture of the base of the first metacarpal bone fully described and illustrated, although a fairly common injury, it is frequently omitted in surgical works.

We should like to see the following statement omitted:—"The best method of treating a fracture of the patella is still *sub judice*," as undoubtedly operative measures give the best results in all cases in which there is any displacement of the fragments. A simple method of ambulatory treatment is given for fractures in the region of the ankle-joint, which should be of great use in hospital cases. In the treatment of tuberculous joints the authors speak highly of injections of iodoform and the artificial production of venous congestion.

The volume, which concludes with an excellent chapter on "Deformities of the Extremities," is illustrated with wood cuts, the majority of which are exceedingly good. We must congratulate the authors on the way they have begun their task, and we await with pleasure the second volume. We can strongly recommend the first to practitioners and senior students.

## AILMENTS OF WOMEN AND GIRLS. (b)

IN this volume the authoress again enters the medicoliterary field bearing the excelsior standard of the physical improvement of her sex. We think it is well to hear a woman's voice sometimes, in the description of conditions and sensations regarding which her evidence is first-hand, while that of man can never reach beyond the "hearsay" stage. There is but too much sad truth in the quotation given in the opening sentence of the preface: "The past generations of women were taught to suffer in silence. . ."; but it is consoling to be told by the same author that "suffering is not woman's necessary lot." The present volume is apparently the outcome of a laudable desire to contribute to the diminution of this suffering. The merit of such aim cannot be called in question. Of course, the enormous scope included prevents the thorough treatment of any of the subjects dealt with;

(a) "Manual of Surgery." By Alexis Thomson, M.D., F.R.C.S. Ed., Assistant Surgeon Edinburgh Royal Infirmary; Surgeon to the Deaconess Hospital, Edinburgh; and Alexander Miles, M.D., F.R.C.S. Ed., Assistant Surgeon Edinburgh Royal Infirmary; Surgeon to Leith Hospital. Volume I.—General Surgery. With 262 wood engravings. Pp. 763 and xvii. Edinburgh and London: Young J. Pentland, 1904.

(b) "Ailments of Women and Girls." By Florence Staepoole, Lecturer for the National Health Society, &c. Bristol: John Wright and Co. 1904. Price, cloth, 3s. net.

but the authoress, judiciously and philanthropically, gives "a serious warning as to the danger incurred by women attempting to treat themselves in any way beyond the moderate limits here laid down." There is a great deal of excellent information and advice given with regard to menstruation and its disorders, which should certainly prove valuable to most female readers, but especially to those of the rising generation. The volume before us is well written, and within the limits imposed by the authoress herself, we cordially recommend it to both mothers and daughters.

## LEFTWICH'S INDEX OF SYMPTOMS. (a)

THIS is the third edition of a useful little book for use on the consulting room table. The rapid sale of a former edition proves that the author's book fills a genuine gap in medical literature. The attempt to systematise so complex a subject could never be completely successful. At the same time much can be done to lighten the pathway of diagnosis, which often lies in deep shadow. The author has wisely drawn attention by means of an asterisk to the more probable diseases, out of the many that often follow a single symptom. An interesting illustration of the multiple significance of a single symptom may be taken in "headache," which may arise from any one of a formidable list of causes. Dr. Leftwich has added a variety of useful and accurate information to the main motive of his book.

WE have received from the Scientific Press another contribution to the evergreen subject of "Medical Tuberculosis: Its Natural Cure," written by R. B. Searle, L.R.C.P., M.R.C.S., L.S.A., Mayor of Dartmouth. The most charitable remark we can make concerning this venture is that it is an amusing little monograph, which can hardly be considered a serious contribution to the literature of progressive medicine. Mr. Searle writes with the enthusiasm and dogmatism of the unscientific faddist, and offers no reliable evidence for the remarkable conclusions at which he arrives. He would treat tuberculosis by the introduction of the typhoid bacilli, and their toxins, a procedure which we believe cannot be supported as justifiable by either experience or experiment. Much of the pathology in this pamphlet is bizarre, as, for instance, the declaration that cancer "may be looked upon as a malignant variety of tuberculosis." We think the author has been ill-advised in publishing his views in such a form. His manner and method of presentation are not likely to further scientific medicine. We are of the opinion that such a work as this is likely to produce incalculable harm should it fall into the hands of ignorant and suffering laymen.

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THE "Edinburgh Stereoscopic Atlas of Anatomy," by David Waterston, M.D., Lecturer and Senior Demonstrator in Anatomy in the University of Edinburgh, marks a new departure in the teaching of that subject. By means of photographs viewed stereoscopically a most lifelike picture is given of dissections of the chief parts of the body. It is needless to remark that nothing can ever take the place of actual dissecting, but at the same time it is impossible to dissect away from the medical school. The student or the practitioner by reference to the stereoscopic atlas can at any time refresh his mind by means of a valuable objective reproduction. The idea is an excellent one, and the Atlas is likely to score a big success. It is to be produced in a series of 250 stereographs at £6 5s. net. The publishers are Messrs. T. C. and E. C. Jack, of Edinburgh.

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"THE Livingstone College Year-Book for 1904" (Leyton: Livingstone College), in addition to particulars concerning the aims and objects of the institution and report as to its recent work, contains a series of hints for the preservation of health in the

(c) "An Index of Symptoms." By R. Winnington Leftwich, M.D., late Assistant Physician East London Children's Hospital. Third edition. Smith, Elder and Co. London: Price 6s. net. 1904.

tropics which will be of suggestive value to medical men and others interested in the selection and examination of missionaries and those who are called upon to live in tropical regions.

### NEW TABLOID PREPARATIONS.

MESSRS. BURROUGHS WELLCOME AND Co. have brought out a "tabloid" of calomel and opium. Each disc contains Calomel, gr. 1; powdered opium, gr.  $\frac{1}{4}$ . "Tabloid" calomel and opium will be found a good means of securing the combined action of the two drugs. Each product is prepared with pure drugs presented in a condition to disintegrate quickly after administration and promptly produce the therapeutic effect. This preparation is likely to be appreciated, in view of the well-known tendency of calomel pills to become hard.

ETHYL-MORPHINE hydrochloride, issued under the name of Dionin, is said to have been recently submitted to clinical trial with satisfactory results. From the published reports this agent appears to possess definite analgesic properties, and at the same time to be free from the disadvantages so often associated with the employment of morphine and its salts. No instance of euphoria or euphoric symptoms following the use of Dionin has been recorded. It possesses the further advantage of being, with the single exception of codeine phosphate, the most soluble of the morphine derivatives. The properties of Dionin render it specially useful in ophthalmic work. It is used in iritis, keratitis, glaucoma, vitreous opacities, corneal opacities, and sympathetic ophthalmia; but is contra-indicated in arterial sclerosis of the aged.

THERE is no need to remind medical readers that combinations of sodium bicarbonate with calomel and with grey powder respectively are usually prescribed in the form of powders. There are, however, certain disadvantages associated with the administration of medicines in that form. Messrs. Burroughs Wellcome and Co. have now introduced these useful remedies in "tabloid" form, so that in future medical men will be assured that their patients will obtain full and accurate doses of absolutely trustworthy drugs. The two new tabloids are "tabloid" calomel and sodium bicarbonate, and "tabloid" grey powder and sodium bicarbonate, made up in varying doses.

ANOTHER "tabloid" issued by the same firm is that of the three valerianates—Quinine valerianate, gr. 1 (0.065 gm.); iron valerianate, gr. 1 (0.065 gm.); zinc valerianate, gr. 1 (0.065 gm.). A combination highly praised in some quarters as an efficient tonic. Still another "tabloid" is the valerianate of zinc in combination with 1-60th gr. of arsenious acid and 1 gr. of reduced iron.

## Medical News.

### Therapeutical Society.

AN informal meeting of this society was held in the gardens of the Royal Botanic Society, Regent's Park, by permission of the secretary, J. Bryant Sowerby, Esq. Dr. F. de Havilland Hall was in the chair, and fifteen Fellows attended the meeting. Dr. Brown, the secretary of the Therapeutical Society, showed specimens of the seeds of the Sapota cedron, sent by J. H. Hart, F.L.S., from Trinidad, and some Chinese medicinal roots from Miss Florence Cooper, of Lo'nguog City, Fouchow, China, both persons being corresponding Fellows of the Therapeutical Society. Mr. Bryant Sowerby showed various specimens of medicinal plants and drugs, and also a very fine plant of the Victoria Regia in full bloom, and numerous other medicinal plants and trees growing in the garden. The Fellows present afterwards had tea in the club in the gardens.

### The Cholera in Persia.

A REUTER'S telegram states:—"The *Transcaspian Review* states that the cholera at Teheran has lost its menacing character. The mortality has decreased from 1,500 deaths daily to 300. There is panic only among the natives, who, in consequence of the enor-

mous rise in the prices of provisions, have fled into the country. The measures taken by M. Grube, the Russian Financial Agent, with the assistance of the Russian Legation, have averted disturbances. By the flight of the inhabitants the cholera has been carried into the surrounding country, and it is now raging in the villages. When these people return to the city there is a possibility of the epidemic, as in 1892, again assuming a dangerous character."

### Action for Malpractice.

AN action was heard at Belfast on July 21st and 22nd, before Mr. Justice Wright, in which Mr. Alfred Ernest Inghan, a minor, sought to recover £250, on account of personal injuries alleged to be due to the negligence of Dr. C. K. Darnell, of Bangor the defendant. The alleged negligence was in the prescription of belladonna liniment, as a result of which it was said the plaintiff's life became in danger, and he suffered extreme pain, becoming delirious for some time. Defendant denied negligence on his part, and stated that any injuries that had occurred were solely caused by the negligence of the plaintiff's friends. Several expert witnesses were examined, and the jury, after considerable deliberation, disagreed, and were discharged.

### The London Hospital Medical College.

THE following distribution of prizes was made last week to the successful students during the session 1903-1904. "Price" scholarship in science, £120, Mr. W. H. Palmer; "Price" scholarship in anatomy and physiology, £60, H. S. Souttar; entrance science scholarship, £60, J. E. Scudamore; entrance science scholarship, £35, J. P. Johnson; "Buxton" scholarship, arts, £30, J. G. Watson; "Buxton" scholarship, arts, £20, G. S. Candy; Epsom scholarship for students of Epsom College, D. G. Evans; clinical medicine, £20 scholarship, J. Lambert; clinical surgery, £20 scholarship, E. Ward and J. Lambert; clinical obstetrics £20 scholarship, A. J. Walton; "Andrew Clark" prize, £26 (biennial), A. J. Walton; "Letheby" prize, senior, £20, G. S. Candy; "Letheby" prize, junior, £10, F. Hitch; "Sutton" scholarship, £20, A. J. Walton; anatomy and physiology, £25, R. C. Roberts; anatomy and biology, £20, J. P. Johnson. Together with several minor prizes and hon. certificates.

### The Prevention and Treatment of Cancer.

IN view of the increasing prevalence of cancer, the Committee of the Liverpool Cancer Research deem it their duty to call attention to what may be done to combat this increase. No specific cure for cancer is yet known, but, as with consumption, the earlier the treatment is commenced the greater is the chance for its success. Unfortunately, a large number of people put off seeking the advice of their doctor instead of going to him immediately they notice anything wrong. It may be pointed out that certain organs are more often affected than others. In men, cancer of the gullet, stomach, and intestines; in women, cancer of the breast and the womb, account for about two-thirds of all cases of cancer. There are, of course, many other only slight ailments of these organs. The Committee feel that they cannot too strongly state how important it is that the disease should be recognized at the earliest possible moment. This recognition can only be attained by the patient going to his or her doctor for examination at the very beginning of illness.

### The Royal University of Ireland.

THE Senate met on Thursday, July 28th, the Right Rev. Monsignor Molloy, D.D., D.Sc., Vice-Chancellor of the University, in the chair. The secretaries reported the deaths of the following members of the Senate:—William A. McKeown, M.D., on July 9th, and Edmund Dease, M.A., on July 17th. The following resolution was proposed by Sir Christopher Nixon, seconded by Rev. Dr. N. McA. Brown, and passed unanimously:—"The Senate desires to record its deep regret at the death of William Alexander McKeown, M.D., and to express its high appreciation of the zeal and energy with which he devoted himself to the interests of the University, especially to those

of the Medical Faculty, from the time of his appointment as Senator at the foundation of the University."

The following resolution was proposed by His Honour Judge Shaw, seconded by His Grace the Most Rev. Dr. Healy, Archbishop of Tuam, and passed unanimously:—"The Senate desires to record its deep regret at the death of Edmund Dease, M.A., who has been a member of the Senate since the foundation of this University; and to express its sense of the benefits which the University derived from the wide experience of public affairs, the high sense of duty, the unswerving integrity, and the unflinching courtesy which Mr. Dease brought to the deliberations of the Senate."

#### Irish Medical Schools' and Graduates' Association.

THE summer general meeting of the above Association was held on Wednesday, July 27th, at the University Museum, Oxford, the President, Surgeon-General Sibthorpe, C.B., in the chair. Among those present were Sir Charles A. Cameron, C.B. (Dublin); Lieut.-Colonel Boileau, M.D., A.M.S. (Trowbridge); Dr. James Little (Dublin); Dr. Percy V. Dodd (Folkestone); Dr. William Douglas (Goudhurst); Dr. Robert Esler; Dr. T. Gelston Atkins (Cork); and the provincial hon. secretary, Dr. James Stewart (Clifton). The following resolution, proposed by Dr. Atkins, and seconded by Sir Charles Cameron, was passed unanimously:—"That a copy of the two resolutions adopted at the Special General meeting of May 25th be sent to the Chairmen of the various Boards of Guardians throughout Ireland, together with any additional statements the Council may think fit to forward, with a view to strengthening the case of the Irish Poor-Law medical officers." The meeting then adjourned.

#### University of London.

THE following candidates have passed the M.D. examination:—Hugh Barber, Helen Beatrice Hanson, Arthur Charles Haslam, Septimus M. Hebblethwaite, Norris A. Houghton, Colin Dunrod Lindsay, John Ford Northcott, Claude Rundle, Richard Hamilton Townend. William Ferris, B.S., passed in Mental Diseases and Psychology. The following have passed in Midwifery and Diseases of Women:—James Cole Marshall, Richard Maxwell, Thomas M. Pearce, George S. Robertson. Myer Coplans passed in State Medicine. The following have passed the M.S. Examination:—William Henry Bowen, David Leighton Davies, M.D., Walter Fedde Fedden, Sydney Richard Scott, Robert Gordon Strange.

#### Royal Colleges of Physicians and Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

At the July sitting of the Scottish Conjoint Board, held in Glasgow, the following candidates passed the respective examinations:—

*First Examination five years' course*—Alexander M'Murray, Belfast; John M'Kelvey, Belfast; Ernest Gibson, Cork; William G. Forde, Cloyne; Henry W. Turner, Glasgow; Osmonde R. Belcher, Cork; Thomas B. Ferguson, Kirkmaiden; Frank H. A. Riddle, Madras; Patrick J. Taaffe, Liverpool; John G. Buchanan, Tیره; David Welsh, Wilsontown; Karl F. Gover, Demerara.

*First Examination four years' course*—George V. Edwardes, Keatley.

*Second Examination five years' course*—John R. D. Holtby, Belfast (with distinction); John A. Smith, Glasgow; Fred. G. Allan, Whaley Bridge; John M. Muir, Kilmarnock; Joseph H. Patterson, North Berwick.

*Third Examination*—Alexander Brown, Galston; Percival Henderson, Skelmersdale; John Macnamara, Leitrim; John M'Arthur Falderbank; John M. Moriarty, Kerry; William F. H. Ives, London; Henry E. Bolton, Dublin; Joseph B. N. Raphael-Tom, Trinidad; John H. R. Bodedern, Anglesea.

*Final Examination* (and admitted licentiates of the three co-operating authorities):—James B. Patterson, Carlisle; Archibald F. G. Spinks, Southport; Robert Crothers, Banbridge; Thomas G. Campbell, Glasgow; William A. Magill, Belfast; George H. Waugh, Belfast; Llewellyn C. Nash, New Sheldon; Percy J. Thomson,

L.D.S., Glasgow; Thomas A. Fall, Partick; Henry E. Strathy, Pitlochry; Reginald W. Towney, Oswaldtwistle; Mathias A. L. dos Santes Vaz; John H. Fyfe, L.D.S.; Laurence Gavin, and David Haig.

#### Royal Colleges of Physicians and Surgeons in Ireland.

*Third Examination*.—Candidates have passed this examination as understated—Passed in all subjects—T. A. Burke, M. Cohen, E. G. Condon, P. F. Foran, W. Glennon, C. W. Greene, W. P. Kelly, T. H. Massey, M. O'Connor, J. R. Tobin, and C. H. Wilson.

*Completed Examination*.—R. Calnan, C. J. R. Clarke, S. C. Clarke, T. W. Conway, J. Corboy, J. B. Dwyer, T. J. Golding, P. E. Hayden, R. F. Hayes, H. Hosty, A. E. S. Irvine, L. F. Kelly, M. J. C. Kennedy, F. G. M'Caughy, T. J. Madden, R. V. Murphy, J. O'Donnell, W. D. Sammon, P. D. Sullivan, W. G. Wright.

*First Examination in all subjects*.—P. J. Timoney.

#### University of Birmingham.

THE following candidates have passed in the Faculty of Medicine:—

*Degree of Doctor of Medicine*.—(a) Official: John Douglas Stanley; (b) Under Ordinary Regulations: Jordan Lloyd.

*Degree of Master of Surgery*.—Official: John Thomas Hewetson and Thomas Wilson.

*Degrees of Bachelor of Medicine and Bachelor of Surgery*.—(a) Associate: Alex. Wathen Nuthall. (b) Past students of Birmingham Medical School; Tom William Beazeley, Charles York Flewitt, Sidney Cameron Lawrence, and William Arthur Loxton. (c) Under Ordinary Regulations; Alfred Ernest Remmett Weaver (scholarship), William Cook, Cuthbert Keay Gettings, and Leonard George Joseph Mackey.

*Degree of Bachelor of Dental Surgery*.—Henry Percy Pickerill.

*Diploma in Public Health*.—Parts I. and II. Thomas Dawson.

#### Conjoint Examinations in Ireland—Final Examination.

CANDIDATES have passed this examination as undernoted:—

*With Honours*.—James S. Sheill.

*Passed in All*.—Miss Alice M. Barry, Mathew Campbell, William I. Cowell, Michael Keane, William F. B. Loughnan, William L. Murphy, Arthur Lanigan O'Keefe.

*Completed*.—Andrew J. Bracken, George P. A. Bracken, Alfred N. Crawford, Christopher A. Cusack, Benjamin D. Gibson, George A. D. Harvey, Patrick Kinsella, Francis J. Lennan, William J. O'Sullivan, James Parker, and Thomas J. Ryan.

THE President of the Royal College of Physicians of Edinburgh, Dr. T. S. Clouston, recently announced the postponement of the consideration of a suitable dress for licentiates of the College. It is somewhat difficult to understand why this subject should be so persistently shelved by the authorities of that body. The recently formed association of Scotch diplomates has urged the Scottish Colleges to take some steps in this easily-arranged matter, and offered further to submit the design of a dress for approval. The Colleges declined that offer, but have not produced their own pattern. Licentiates and Fellows, however, will doubtless get that and other things, if they wait—and organise. The Hon. Sec. of the Scottish Diplomates' Society is Mr. Heather Bigg, Harley Street, London, W.

H.M. THE KING has appointed Sir William MacGregor, M.D., K.C.M.G., C.B. (Governor of Lagos), to be Governor and Commander-in-Chief of the Island of Newfoundland and its Dependencies.

UNDER the will of Mr. Henry Evans, banker, of Highfields, Derby, who died suddenly last week, the Derbyshire Royal Infirmary receives ten thousand pounds for the equipment of a permanent ophthalmic department.

DR. URBAN PRITCHARD delivered his valedictory address at Bordeaux, on Monday last, at the international Congress on Otology, at which Dr. Moure was unanimously elected President. All the countries of Europe and the United States of America were represented.

## 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.

### THE HUMANE SLAUGHTERING OF ANIMALS.

THE recently published report of the Committee appointed to consider the Humane Slaughtering of Animals has pronounced emphatically in favour of public as against private slaughter-houses. (1) "In the interests not only of humanity," it says "but of sanitation, order and ultimate economy. It is highly desirable that, where circumstances permit, private slaughter-houses should be replaced by public abattoirs, and that no killing should be permitted except in the latter, under official supervision. (2.) The Committee no less emphatically condemns the Jewish system of slaughtering as at present practised, and reports that "until some method is devised, and adopted, for rendering the animals unconscious, previous to the 'casing' and throat-cutting operations, the Jewish system of slaughtering cattle should not be permitted in any establishments under Government control."

**PHARMACIST (Newcastle).**—Yes—a remarkably good action has been claimed for large doses of digitalis (4 grms. daily of the infusion) in the treatment of pneumonia. The introducer of this method, Braggadonia attributes the good effect to the antitoxic action exerted by digitalis against the metabolic products of Fraenkel's bacillus. The method deserves a trial.

**STUDENT.**—Yellow fever can be conveyed across the sea by ships that have no disease on board. It is distributed from person to person by a species of mosquito (*Styomyia Fasciata*), which harbours in water tanks and damp places. See an excellent note on the subject in the recently published Annual Report for 1903 of the Medical Officers of Health of the Bristol Port Sanitary District.

**R. M. BENNETT.**—If when an assistant you signed an agreement not to practise within a radius of four miles of your principal's residence you are practically excluded from practice in London. A clause of the kind under such circumstances is most unfair, and no assistant should be asked to put his name to anything of the sort.

A VERY distinguished doctor (writes a correspondent) tells the *Daily News* that the medical profession appears to be undermined only because of the difficulty at this time of the year in finding "loci tenentes." What a pity! Is this turning about of familiar Latin phrases, as the lady proved who talked of "omnibi," or as that other showed us who talked of "a state of doubtful ebriety"? Let us hope that the medical profession will not long have to deplore the want of "loci tenentes," or someone is sure to remind us very soon of what we seem to have heard before, that the medical profession used to be a very different thing. As the brilliant Fellow of All Souls remarked when deploring the decline of intellect in the younger Fellows, "D— it. We use to be *sus generis*."—*Manchester Guardian*.

**J. FRAUVAL (London).**—We do not know of any book dealing with the subject you mention. The general opinion of the medical profession is undoubtedly unfavourable to consanguineous marriages. It is impossible to approve of first-cousin marriages from the point of view of the interests of offspring.

## Vacancies.

- Ayr District Asylum.**—Junior Medical Officer. Salary £120 per annum, with board, furnished apartments, attendance, and washing. Applications to the Medical Superintendent.
- Brighton Throat and Ear Hospital** Church Street, Queen's Road.—Non-resident House Surgeon. Salary £75 per annum. Applications to Secretary, Mr. E. W. Pilbeam, 10 Black Lion Street, Brighton.
- House Surgeon**, for a small Hospital in the Midlands. Salary £100 per annum and board. Applications to Mr. P. W. Walker, 18 Waterloo Street, Birmingham.
- Humberstone Asylum, Leicester.**—Assistant Medical Officer. Salary £200 per annum, with furnished quarters and board. Applications to Medical Superintendent.
- Ingham Infirmary and South Shields and Westhoe Dispensary.**—Junior House Surgeon. Salary £75 per annum and residence, board and washing. Applications to James R. Wheldon, Secret-74 King Street, South Shields.
- Kent County Lunatic Asylum, Barming Heath, near Maidstone.**—Chief Medical Officer and Superintendent. Salary £800 per annum, with unfurnished house, coal, gas, milk, garden produce and washing for self and family. Applications to Francis R. Howlett, Clerk, to the Sub-Committee, 9 King Street, Maidstone.
- Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Northwood.**—Resident Medical Officer. Salary £80 per annum, with board and residence. Applications, to William J. Morton, Secretary 7 Fitzroy Square, W.
- Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Northwood.**—Honorary Dental Surgeon. Applications to William J. Morton, Secretary, 7 Fitzroy Square, W.
- North Cambridgeshire Hospital, Wisbech.**—Resident Medical Officer. Salary £100 per annum, with furnished rooms, attendance, coals, gas, and washing. Applications to William F. Bray, Secretary.
- Rotherham Hospital and Dispensary.**—Senior House Surgeon. Salary £110 per annum, with rooms, commons, and washing. Applications immediately to the Secretary, C. S. Baylis, 19 Moorgate Street, Rotherham.

The Aberaman and District Workmen Doctors Fund Committee.—Qualified Gentleman to take charge of a large Colliery District Practice. Salary £400 per annum, with free house, coal, assistants, dispenser, drugs, &c. Applications to Secretary.

## Appointments.

- COOPER, WILLIAM P., L.R.C.P. & S. Edin.,** House Surgeon to the Royal Westminster Ophthalmic Hospital.
- DALLY, J. F. HALLS, M.A., M.B., B.C. Cantab., M.R.C.S., Eng., L.R.C.P. Lond.,** Senior Resident Medical Officer to the Royal National Hospital for Consumption and Diseases of the Chest, Ventnor, I. W.
- DENT, CLINTON T., F.R.C.S. Eng.,** Chief Surgeon to the Metropolitan Police.
- DONALD, C. W., M.D., F.R.C.S.E.,** Surgeon to Cumberland and Westmoreland County Constabulary.
- DUPOUT, J. M., M.B., Ch.B. Edin.,** Assistant Resident Medical Officer to the Royal National Hospital for Consumption and Diseases of the Chest, Ventnor, I. W.
- NICHOLSON, HARRY OLIPHANT, M.D. Aberd., F.R.C.P. Edin.,** Assistant Physician to the Royal Maternity and Simpson Memorial Hospital, Edinburgh.

## Births.

- COOKE.**—On July 26th, at Church Square, Haddenham, Bucks, the wife of Frederick A. Cooke, M.D., M.R.C.S., L.R.C.P., of a son.
- FINLAY.**—On July 28th, at No. 10 Clarendon Road, Eccles, Lancs, the wife of G. L. K. Finlay, B.A., M.B., C.M., of a daughter.
- HARPER.**—On July 27th, at 7 Chiawick Place, Eastbourne, the wife, Alexander Harper, M.D., of a daughter.
- HARVEY.**—On July 21st, 1904, at 7 Gardiner's Row, Rutland Square, Dublin, the wife of E. J. Harvey, F.R.C.S.I., of a son.

## Marriages.

- WACHER—PEEBLES.**—On July 28th, at St. Alban's Church, Windesham, Harold Wacher, M.B., eldest son of Frank Wacher, of Monastery House, Canterbury, to Violet Amy, daughter of the late Robert Davie Peebles, of the Priory, Heene, Worthing, and of Mrs. Peebles, of Fosters, Windesham.
- WHITTINGHAM—DUKES.**—On July 27th, at St. Michael's, Bournemouth, Edwin Parton, eldest son of Edwin Whittingham, of Bournemouth, to Amy Barbara, only daughter of the late W. P. Dukes, M.R.C.S., of Spitalfields, and Mrs. Dukes, of Christchurch.

## Deaths.

- CRANNY.**—On July 27, at 17 Merrion Square, Dublin, John Joseph Cranny, M.D., F.R.C.S.I., eldest son of the late Patrick Cranny, of Muckross Park, aged 69 years.
- CROCKER.**—On July 18th, at West Malling, Kent, Henry Leonard, fourth son of the late Surgeon-General Alfred Crocker, Army Medical Department.

## OPERATIONS.—METROPOLITAN HOSPITALS.

- WEDNESDAY.**—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopaedic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street (9.30 a.m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- THURSDAY.**—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynecological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- FRIDAY.**—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopaedic (2.30 p.m.), Soho Square (2 p.m.).
- SATURDAY.**—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (10 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- MONDAY.**—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynecological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopaedic (2 p.m.), City Orthopaedic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).
- TUESDAY.**—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, AUGUST 10, 1904.

No. 6.

## Original Communications.

### A CONSIDERATION OF SOME OF THE DIFFICULTIES MET WITH IN THE EXPERIMENTAL TREATMENT OF CANCER. (a)

By SKENE KEITH, M.B., F.R.C.S.ED.

It is said that every young lawyer has visions of sitting one day on the Woolsack, and it is probable that the dream of discovering a cure for cancer occurs at one time or another to every medical student. He dreams of the benefit to humanity and of the glory to himself.

It is a subject we have all to consider, and I have tried to put together some things about it which have occurred to me, not from the scientific investigator's, but from the practical experimenter's, point of view. One turns the subject over and over, and perhaps comes to think that one has at last settled in one's own mind something definite. Then comes reconsideration, and at once doubt appears. Still, for experimenting I believe that one must take up a definite line. Once there is a commencement, it is not so very difficult to progress and to improve. Take, for example, the X-rays; at first the difficulty was to prevent a burn. Experts can, I understand, prevent this, and a burn now means either ignorance or carelessness. Nothing shows more clearly the state of ignorance we are in than the apparently almost universally held idea when radium was discovered that here was the cure so long sought, and this before anyone knew hardly anything at all about the subject.

There are many difficulties in the experimenter's way. One great one is that it comes to few to have the opportunity of making practical experiments. An occasional patient turns up, and, if the growth is capable of being removed, no experiment can be tried. If the disease is far advanced, it may seem unkind to suggest increasing, perhaps, the already sufficient miseries. Even in hospitals this difficulty also prevails, because it is impossible to admit any but the smallest number of those who are beyond operative interference, simply for the sake of experiment, when there are so many for whom something can be done, or at least attempted.

If this difficulty has been surmounted, a much greater one immediately appears, for what is cancer? how does it come? why does it kill when there is no exhausting discharge, and when situated in a part of the body not necessary to existence?

Cancer, or widely malignant disease, is divided pathologically into two main groups—*viz.*, those spreading through the blood and those spreading through the lymphatics. Does this help us for treatment? Are we to take pathology into account in experimenting, or are we to ignore it? The amount of success which has been obtained by the administration of the toxins of erysipelas and the Bacillus

prodigious—Coley's fluid—in the treatment of sarcomata seems to point to the advisability of at least considering whether, for treatment, it may not be well to divide the cases into groups. But on the whole, pathology, even the latest discoveries of the conditions of the cells, does not at the present time, at all events, seem to help us much.

Already there are several who claim credit for first making the discovery that "the cells in malignant disease undergo a reductive division similar to that occurring in the formation of sexual cells, whereby germinal tissue is formed." It would take an expert to decide this question of priority, but it seems probable that Dr. George Beaton was the first to come to this conclusion as to the nature of the cells, the result of practical experiments, his experiment of the removal of the ovaries for inoperable cancer of the breast being based on physiological grounds; and the clinical observations he made induced him to come to the conclusion that cancer was due to a local conversion of the cells affected into germinal tissue. Here pathology is following, as so often has been the case, in the treatment of diseases.

How does it come? why has it come? to me are common questions. People can realise the infection from, say, scarlet fever, or an attack of pleurisy, or pneumonia, the result apparently of a chill, but they do not understand, if there has been no injury and no family history of the disease, why cancer should come to them. We also are faced with the same difficulty. In some cases doubtless there seems to be a distinct connection between a prolonged irritation and the occurrence of the disease, but surely there must be something more, or why does not a similar irritation produce it in all? Women often trace a connection with a blow, especially on the breast, but every woman who has cancer of the breast does not know of any injury, and many must be injured in that region without the disease resulting. No, the irritation or injury theory is not enough.

Heredity—this question opens up so many fallacies that it is impossible to dogmatise on the subject, for the same thing occurs here as with injuries; all who have a family history of the disease do not have it, and some have it where there is no known family history. My own opinion is that it is the rule rather than the exception that the tendency to the disease is handed down from one generation to another. How many people, even in good circumstances, can tell the cause of death for two generations, especially where there is a large family? But to go back two generations is probably not enough, especially if we are to accept as a fact that a disease—for example, syphilis—can be traced through five generations. There are some who do not believe that heredity plays any part, but they do not advance any theory to take its place. Is it caused by a germ or a parasite? This question is, like most others connected with the subject, still only a conjecture. What is there in the disease to cause death? Why is there the steady loss of vitality? A satisfactory answer to this question might help in our search for a remedial agent.

Is the disease in the beginning a local one, or is the growth a local manifestation of a general condition.

(a) Read before the Cambridge Medical Society, February 5th, 1904.



or is it sometimes one thing and sometimes the other? If it were local, is it probable that there would be so often a return after removal, or is it that a return always means incomplete or too late operation? If the latter, why should the disease lie dormant for years, and then apparently start into existence, sometimes with, sometimes without, any exciting cause? Whichever theory is held, in practice it must be evident that the hope, at least, is that it is a local disease. An operation performed with the expectation of accomplishing a permanent cure points to the local theory. If the local theory is held, then all idea of heredity must go, unless it is believed that the disease is due to the improper development or arrangement of some of the embryonic cells, and that the tendency to have such can be inherited, the offspring of a person born prematurely being more prone to such conditions. The possibility of this amount of heredity was suggested to me by Mr. Richard Cowen, and the idea seems to be a novel one. Otherwise the disease must have something general in its nature if it is to be handed down. The experiments we have heard most of lately all attack the disease locally; the X-rays and bromide of radium are both local in their action, and, as far as is at present known, have no power of preventing the disease appearing in other parts. At present their use seems to be limited to cases of rodent ulcer and to the removal of small nodules, either by absorption or by a caustic action, but it is a great misfortune that so many patients have had the pain of an X-ray burn—a different thing to an ordinary burn—added to the sufficient miseries connected with the close of life by cancer. It is known that the injection of quinine and other substances increases the beneficial action of the rays, so it may be that in this or in some other way their action may be extended to deeper parts. I do not think that the theory of a general condition, and with this the influence of heredity, should be ignored. It frequently happens that after an apparently satisfactory operation the disease returns as quickly as if the original growth had not been removed. One has seen so many disappointing cases of this kind that one must feel inclined to accept this theory of a general condition unless the middle course is to be taken, and we are to believe that there are two distinct causes at work, the local and the general. This would be a simple, but very unsatisfactory, way out of the difficulty.

There is, however, one point on which everyone is agreed, and that is that with the amount of knowledge we possess at present it is impossible for anyone to feel sure one way or the other.

We come to another matter which may bear much on the subject. It is the great difference there may be in two apparently identical cases in malignancy. One case runs its course in, perhaps, a year; in another the disease may exist for two, three or more years. This may be partly explained by age, in the young the course being usually more rapid than in the old, but this is not the whole explanation. The elucidation of this point would also help us towards a cure.

So far I have dealt with difficulties more perhaps theoretical than practical, but they have been considered because they lead up to the great practical difficulty of deciding or suggesting what line experiments are to take. A form of treatment, if we come to the conclusion that the disease is a local one, and which then might be sensible and appear right, could not do so if we take the line that the local growth is the result of something else.

A very practical matter has now to be considered. At the present time the recognised method of treating the disease is by operation. It is recognised in all the books and at all the medical schools that surgery, especially if the case is seen early, may cure either temporarily or permanently, and at present no one doubts that this is a proper view to take. It is, however, a view which renders all experiment difficult, almost hopeless, because the patient, when he comes to the experiment stage, is saturated with the disease and the vital powers are so much reduced that the

action of drugs seems often to be modified. In cases of this nature also, the patient and the doctor are both ready to clutch at straws and to be encouraged, by slight improvements, into the belief that a curative agent on the disease is being used when it is one which only alleviates symptoms caused by the disease. This can often be easily accomplished. Such treatment would not affect the disease in the early stages and before it has existed long enough to affect the general health. It is, however, in the early stages that one would expect that a remedy which actually combated the disease, and not the results of the disease, would have most chance of effecting a cure, and as an example of this the following cases may be mentioned. The two cases were those of a husband and wife, both being just under forty years of age. The mother of the wife had died of cancer of the stomach. On the husband's side there was no history of cancer, as far as he could ascertain. The lady had noticed a lump in her right breast some months before she first consulted a doctor. By this time there were two ulcerated patches, said to be roughly the size of a shilling, on the breast. The first doctor consulted gave the opinion that no operation was possible, as there was a mass connected with the ribs. A hospital surgeon gave a similar opinion, and this was confirmed by a third. At the first visit the lump in the breast was the size of half a hen's egg; the mass connected with the ribs was very large. It felt about an inch thick, and was fully four inches in diameter. There was little pain, but great loss of strength and weight. In such a case, an experiment would be recognised by everyone as being a fair thing to try, and a form of treatment by hypodermic injection of various drugs, and which my brother and myself have been experimenting with since the beginning of last year, commenced. The case improved steadily, the ulcerations healed, the mass in the breast disappeared, and the one connected with the ribs was much reduced. At this time, after the wife had had twenty-seven injections, the husband came to show his tongue, as it had been painful at night and had looked ulcerated for five weeks. An irregular ulceration with a hard base three-quarters of an inch long and a quarter of an inch wide was seen on the edge of the tongue. There was no history of syphilis—the patient fully realised the necessity of being truthful on this point—nor were there any evidences of it to be found. To be on the safe side  $\frac{1}{4}$  gr. of perchloride of mercury was ordered to be taken three times a day. For about one week the ulceration looked cleaner, but continued to increase in size, and after three weeks of this treatment the ulcer was over an inch in length. The treatment now lay between removal of half of the tongue back to the hyoid bone, or a trial of an experiment somewhat similar to what his wife had been undergoing. Eleven injections removed entirely the hard base, and healed the ulcer, while at the same time the pain was relieved completely. For the time being the case is cured, but as time alone will show if the cure is permanent I only bring it forward at present as an indication of how much greater and quicker the results may be expected when experimenting on early cases; nor do I wish to enter into the question of whether one is justified in advising an experiment in a case suitable for operation. My object is rather to suggest the advisability of experimenting on cases of cancer of the liver, especially when they are seen in the early stages of the disease, or in any other part where an operation is neither possible nor advisable for any reason. For example, the removal of deeply seated malignant growths in the neck is seldom a satisfactory operation, and an experiment on such a case might be considered to be as likely to do good as an attempt at removal. The only objection there seems to be to doing this is that it is by no means easy to make the diagnosis in the early stages, especially when the disease is situated in an internal organ of the body. In other respects there does not seem to be any objection, because the patient does not lose any valuable time, and thus, while an experiment may do no good, it need not result in any harm.



Until quite recently it might almost seem that hope of discovering a cure for this dread disease had been abandoned, and that all attention was being concentrated on improving the methods for its removal. In this direction there can be no doubt that there has been a decided advance, though the pendulum has swung too far, and now, instead of removing too little, the operations are sometimes unnecessarily too severe. Even the public institutions specially devoted to the treatment of cancer appear to have contented themselves with doing their best for the individual patient by improving their methods, but always on the same lines.

Privately, it is probable that many experiments have been made, but in so far that they have come to nothing there has been no occasion to say anything about them. My brother and myself have been experimenting for a number of years both with possible remedies we had ourselves thought of, and also with those suggested by others. Some day we hope we may be able to bring forward the details of something satisfactory, but failure, repeated time and again for over fifteen years, teaches one to be in no hurry to be enthusiastic, and the more one works at the subject the more difficult it seems to be to know when a cure can be claimed, or, indeed, to feel at all sure that one knows anything very definite about the subject.

The question of the greatest practical difficulty has been already referred to—*viz.*, that of not getting the cases early. Patients come after they have tried to believe in the so-called Christian Science, but their faith has probably been weak—after X-rays, high frequency, and operations, with a quick pulse, a yellow skin, and all the symptoms of an early parting of the ways—and they ask can nothing further be tried for them. It is distressing to have to say that there is no treatment for such a case, but what is the use of trying to cure any patient in the last stages of the disease? The question of the curability of cancer has been taken up by the daily papers. This publicity is not altogether a misfortune, because, by making patients think that a cure may be found out some day, or may be in the process of being found out, they are, at least in our experience, more anxious to try an experiment than they were before the special cancer hospitals and the Royal Colleges began to experiment and investigate. As experiments cannot be made without money, the public have had to be taken into the confidence of the profession. These public appeals have given rise to hope; patients who formerly would have been resigned when told that nothing could be done for them are now inclined to try something—anything. So long as the experiments are properly carried out, and the patient fully realises that it is experimental, no harm need be done. But it is different when a treatment about which we understand little, such as exposure to the X-rays, is undertaken by incompetent persons. Much harm may and has been done, and many painful burns and a number of deaths have resulted from the careless or ignorant use of the rays. It is apparently forgotten that every care must be taken to prevent an experiment doing harm. I do not wish it to be understood that I would not approve of the X-ray experiments being continued. Very far from it, but I would ask that unqualified persons should not be allowed to treat patients with a force which not only may cause most painful burns, but which has actually caused death in a number of instances, from sudden absorption of the breaking down tissues of the growth itself.

When one writes of a cure being discovered, nothing sudden is meant. It is difficult to see how it is possible to discover a cure without some years of patience, for one cannot fairly say that any patient is cured until some years after treatment. It is on this question that one can legitimately complain of the lay papers. Cures have been reported; for example, one doctor was stated to have announced that he had cured several cases by the use of radium, and we all know that radium has been discovered for months rather than years; someone else has discovered the cure in salt;

another in molasses, and so on. It is not likely that any doctor with any reputation to lose has given out statements of such a kind.

I have shown that the treatment of cancer has been almost entirely directed to the cure of the local condition. It would be foolish to say that everything has been done locally that can ever be done, but I would suggest that more attention be given to experimenting as if the disease were a local manifestation of a general condition. If we knew why the disease caused loss of strength, loss of weight, and deterioration of the blood, it might be that we would be near to the discovery of a curative agent. At present, investigations have not reached this point of the subject.

Our own experiments, passing by the more scientific aspects of the question and limiting ourselves simply to attempts to discover a curative agent, have been directed since the beginning of last year to attacking the disease through the general condition.

Experiments may be divided into the following groups:—First, cure of the disease; second, relief of symptoms; and third, improvement in the general or local condition, or of both, so as to bring an inoperable case within the range of surgery, to be followed by further treatment in the hope of effecting a permanent recovery. An example of the first has been already given, the cure at present being a cure only in so far that there are no symptoms and no sign of disease. An example of the second was a case of extensive cancer of the liver, where there was severe pain, great loss of strength, and deep jaundice with distressing skin irritation. Though the treatment was begun less than three weeks ago, the pain has been entirely relieved, the strength has come back so much that the patient can walk out alone, which she had not done for some months. The jaundice is less and the irritation is almost completely relieved. In other words the life of the patient will not only be prolonged, but will be prolonged in comfort. An example of the third was that of a lady, *æt.* 55, who had known of the presence of a fibroid tumour of the uterus for nine years. In October, 1902, she was told that she had cancer of the womb and that an operation was impossible. This was confirmed some months later. I saw her in the beginning of December, 1903. The patient was greatly emaciated, very anæmic, and very yellow. The pulse was 108, running up to 120. After consultation with my brother, it was agreed to try preliminary treatment, and then, if possible, remove the uterus. The pulse came down to a steady 92, the anæmic condition improved, and the yellow discoloration of the skin disappeared, and I was able to operate in the end of January of this year. In December an operation would have been indefensible.

So far as we have gone, results have been very satisfactory, but I have purposely not entered into details, because in the past investigators have been far too ready to proclaim success which time has shown to have been premature, and we think that it would be better for everyone in the long run if experimenters were allowed to go on quietly until they had something definite to say, and something which had stood the test of several years rather than, as at present, of only a few weeks.

(NOTE, July 23rd.—There has been no return of the disease in the four cases referred to.)

### THE PRESENT POSITION OF RADIUM IN THERAPEUTICS, WITH A *RÉSUMÉ* OF THE FINSEN LIGHT AND X-RAY TREATMENT. (a)

By C. M. O'BRIEN, M.D., L.R.C.P.,

Physician to the City Hospital for Diseases of the Skin and Cancer, Dublin.

In December, 1902, I had the honour of reading a paper before this Academy on a year's experience of

(a) Read before the Section of Medicine in the Royal Academy of Medicine in Ireland, Friday, May 13th, 1904.

the light treatment in which I described my method of applying both the Finsen light and X-rays, discussing in brief the conditions in each case which appeared to me favourable to the adoption of one or other or both the methods. I found it difficult then, and it would be much more difficult now, to discuss either method separately, for in the general routine of hospital non-selected cases the two methods of treatment markedly overlap, and with best results.

Times beyond count the physician is confronted with the crux in this new case. Which method should he employ—the Finsen light or X-rays? and frequently the question founded on experience irresistibly suggests the answer “use both.” In all such cases (and they are many, especially in lupus), needless to say sentiment and hero-worship must be suppressed and the best method, or a combination of the best methods, only employed in the interest of humanity. In the discussion that ensued on that paper it was suggested that I should again bring forward the cases then exhibited, and in compliance with that suggestion I have the honour of now submitting for your inspection a few who were within easy reach, while holding written replies of a reassuring nature from most of those who have returned to the provinces, where they are at present pursuing their avocations on terms of equality with other members of the community, some after a lapse of twenty-eight years.

CASE I.—A girl, *æt.* 24. Condition on admission to the Skin Hospital in May, 1902: She presented an extensive, yellowish, dark incrustation, involving the *alæ nasi*, tip and bridge of nose, the prominences of both cheeks and greater part of upper lip, the nasal cavity being much encroached upon by lupoid vegetation. The lupus was of four years' standing. She had been operated upon four times under chloroform prior to her admission to the light treatment. She received the Finsen light to the face and X-ray exposures to the nose.

CASE II.—A girl, *æt.* 31. Condition on admission to the Skin Hospital in December, 1901: The lupus had involved both cheeks with considerable destruction of the *alæ nasi* and septum; connecting the patches on both cheeks a band of ulceration, horseshoe in shape, was perceptible, involving the greater part of the bridge of nose. The disease was of sixteen years' standing and had been surgically treated twelve times before her admission to the light treatment, which included both the Finsen light to the face and X-rays to the nose.

CASE III.—A girl, *æt.* 21. Condition on admission to the Skin Hospital in April, 1902: She presented a small, well-defined ulcer involving right *ala nasi*, and extending up right nasal cavity, the mucous membrane of which was swollen, granular, and bled easily. The lupus was of five years' standing, and had been operated on four times under an anæsthetic prior to her admission to the light treatment. She received both the Finsen light and the X-rays.

CASE IV.—A boy, *æt.* 13. Condition on admission to Skin Hospital, December, 1901: He presented a circular ulcer something larger than one shilling situated on left cheek; the edges of ulcer were infiltrated and its base contained typical apple-jelly nodules. The disease was of nine years' duration and had been surgically operated upon under anæsthetics six times before his admission to the light treatment—he received the Finsen light only.

*Memo.*—Of the foregoing cases presented to you for re-examination this evening, and whose histories were given in greater detail, with illustrations, in my former paper, no treatment has been given for nearly a year with the exception of Case I, in whom the disease recurred in the mucous membrane of nose and to whom the high frequency current is at present being applied.

The foregoing *résumé* of the light treatment brings me to the subject of my paper to-night—radium, the latest therapeutic remedy upon which medical science has been called on to adjudicate. This remedy has already received so much notoriety in the lay press that I consider it both opportune and necessary that its therapeutic results should be recorded at once with

accuracy by operators who have tried it, and whose method of procedure has been open to the inspection and investigation of the profession. Thus we spare public feeling the pain of disappointment so often the outcome of sensational exaggeration, while at the same time safeguarding from disfavour and probably disuse a method I believe we are justified in assuming is potent of promise.

I shall not tire you with the history which led to the discovery of radium, with which the names of Madame and Monsieur Curie are so inseparably associated; but what appears to me the most characteristic feature associated with it, and with most of the great discoveries of our own times, is the sequence with which the one led up to and followed the other, compelling Nature, as it were, to divulge her secrets, while at the same time serving as finger-posts to future research.

In 1882 Koch discovered the cause of consumption, and eight years later he declared he had found its cure by injecting tuberculin.

In 1894 Finsen, after years of patient experiment, proclaimed that by concentrating certain rays of the solar spectrum he could kill the bacillus which Koch had found, but failed to conquer.

In 1895 Röntgen convulsed all Germany, and, indeed, the scientific world generally, by his statement that he had discovered rays which could render the human body transparent.

In 1896 Becquerel discovered that uranium emitted rays akin to the Röntgen rays, but weaker, and it was doubtless this important link in that chain which led to the discovery of radium by the Curies two years later.

I shall not dwell on the physical or chemical properties of this great metal, excepting so far as they apply to practical medicine. The power possessed by radium of emitting rays which manifest different penetrative and therapeutic effects is the one property of all others which most strongly appeals to the physician. Whether or not these rays are identical with X-rays is a matter upon which much diversity of opinion at present exists. I am indebted to Dr. Reginald Morton for a copy of a paper kindly sent me, in which he discusses this difficult and important question most clearly and concisely.

An approximate knowledge of the penetrative power of radium rays may be obtained by the ordinary X-ray screen in a dark room. With my own specimen of 5 milligrammes, all I could possibly procure last September of a trustworthy standard, this specimen when held half an inch behind a bar of metal,  $1\frac{1}{2}$  inch thick caused distinct fluorescence of the ordinary X-ray screen, and when held at a distance of three or four inches behind the screen, and the hand interposed between the radium and screen, the general contour of the hand becomes manifest but to a much lesser extent than in the case of X-rays. These experiments are not only interesting, but easy to make.

Unfortunately the supply of radium is so limited that even in the out-patient departments of large skin clinics much difficulty is experienced in procuring suitable cases for this method of procedure. Hence operators are precluded even now from dogmatizing on its therapeutic merits.

The method and duration of its application were additional difficulties which early workers had to encounter, and the difficulty in definitely fixing a period of application which will apply equally to all is well illustrated in the history of my cases given below. Where different patients with like disease, similarly situated, had the same specimen of radium applied under like conditions to patches of lupus of equal size and depth, neither of which were previously treated, in the one case twenty applications of ten minutes' duration were sufficient to establish a cure, while in the other twenty applications of ten minutes' duration were insufficient to create any alteration, excepting slight redness and itching. It may be that personal susceptibility of patient, so important a factor in the Finsen light and X-ray methods, may also have to be reckoned with in the treatment by radium rays.

CASE I.—A male, *æt.* 30, unmarried, clerk, has been

the subject of extensive lupus of the face for twenty years, during which time he has been applying nitrate of silver and other caustics weekly, and has had it scraped under an anæsthetic seven times. He is at present receiving both the Finsen light and X-rays, and is steadily yielding to this course. About two years ago he developed a patch the size of a sixpenny piece over right eye-brow, close to the orbital margin and inner angle of the orbit. The patch was circular in shape, with irregular edges, which were slightly raised above surrounding skin, and capped with a yellowish crust in centre. The position at once suggested treatment by radium because of the extreme difficulty of applying either the Finsen light or X-rays.

On December 16th, 1903, having removed the crust, I applied in close apposition with the patch five milligrammes of radium bromide in a vulcanite capsule, with a circular window of mica, for easy transmission of the radium rays.

From December 16th, 1903, to February 10th, 1904, he had in all twenty applications of ten minutes' duration. Nothing perceptible had occurred in the progress of the case until the end of the fifth week, when the edges of patch became more prominent, slightly redder and an itchy sensation was complained of, with a slight discharge from the patch for the first time. The further treatment was persisted in and five additional applications given, of the usual duration and at intervals as before.

On February 10th, the date of last application, the edges of patch were more swollen and redder, and although the itching had practically ceased, the patient complained of stiffness of the muscles, which became more manifest on wrinkling the brow. The discharge referred to before meantime increased. The treatment was now stopped, swelling and discharge subsided, and three weeks later the patch, although still red, had assumed the appearance of a healthy scar; no external applications of any kind were applied prior to, during, or since the treatment above described.

CASE II.—A girl, æt. 16, was admitted to the Skin Hospital, December 21st, 1903, suffering for about seven years from a patch of lupus, the size of a sixpenny piece, of a reddish colour, with raised edges covered with branny scales. Patient suffered no pain; she sought treatment only because she thought it was beginning to spread and becoming more unsightly. On December 21st, 1903, five milligrammes of radium bromide were applied in direct contact with patch, there being no discharge from sore in this as in the former case which could in any way diminish the radio-activity of specimen employed. Between December 21st, 1903, and March 18th, 1904, sixty-one applications were given.

First month, five applications weekly of ten minutes' duration without manifesting any visible change, excepting a slight redness.

Second month, twenty applications of thirty minutes' duration were given, the redness of margin becoming more pronounced, accompanied by itching but no discharge. February 13th, duration of application was increased to forty-five minutes, of which fifteen such applications were given, with the result the edges of patch became swollen, with the sensation of pins and needles in part, and a discharge on pressure. Treatment was still continued and six further applications were given of sixty minutes each, the last on March 18th, when the treatment was stopped. A week later the pain, swelling, and discharge had diminished. The base of ulcer was clean and healthy-looking, but the edges somewhat raised.

No treatment or external applications of any kind were applied prior to, during, or since the treatment mentioned.

#### CONCLUDING REMARKS.

Radium, to be of practical use in the cure of disease or the alleviation of human suffering, must be forthcoming in much larger quantities, of a recognised standard of activity and at a very much cheaper rate.

From my own experience of the metal, I prefer detailing what I have already achieved and how I achieved it, rather than expressing an opinion on its merits which might in any way circumscribe its sphere of application or prevent others from putting it to the test.

For diagnostic purposes it is very doubtful if radium can ever be of much use. With the X-rays we have much ground for hope in both lupus and rodent ulcer, and combined with Finsen light the results recorded are becoming more universal and more reassuring.

In my previous paper I expressed the belief that the Finsen light for circumscribed superficial lupus had no equal; now, after eighteen months further experience, I am more convinced than ever of its efficacy. But it will be for you, ladies and gentlemen, to say whether or not I have claimed for the method more than my results justify.

#### NEW

### METHODS OF TREATMENT. (a)

(1) SCROFULOUS FISTULA; (2) SCROFULOUS GLANDS; (3) ANÆMIA AND CHLOROSIS; (4) SPASMODIC CONVULSIVE AFFECTIONS.

By LUCIEN WEYLL, M.D.,

Bad-Schwalbach.

FOR all affections of the external organs or affections accessible to external treatment, permanent local baths are of indisputable value.

(1) For many years surgical and gynecological affections have been treated successfully by this method; there is only one affection for which this treatment is not yet sufficiently recognised, that of open scrofulous glands. A great number of these glands treated by this method have, under my care, cicatrised in a short time.

Submaxillary glands open for about one and a half year; (although already operated on) were radically cured within a fortnight.

Sublingual glands, running for several months too, healed within a short time.

The local baths were taken hot (temperature about 86° F.), one to two hours, with a minimum of sublimate, so that the concentration was of 1-100,000.

(2) For closed scrofulous glands I recommended at the Congress, as I had done before in the *Therapeut. Monatss.* of 1900 vaporised sublimate inhalations; concentration, 1-100,000 (the limit of antiseptic effect of sublimate being 1-500,000).

(i) Submaxillary gland, walnut size, inhalation of sublimate vapours three times a day for half an hour. Within six weeks radically reduced.

(ii) Submaxillary glands on either side, walnut size. Within two months almost entirely reduced.

(iii) Sublingual gland, walnut size, reduced after a fortnight's treatment.

Glands of greater dimensions are, of course, not so easy to reduce, the most susceptible to this kind of treatment being the soft and small ones of children; if particularly obstinate they may be made to suppurate, and then treated by the method of bathing mentioned before.

What concerns sublimate vapours inhalation in case of initial catarrhal affection of lungs? (See my article on this subject, *Therap. Monatss.*, Prof. v. Liebreich.) Sublimate 1-100,000, not pulverised but vapourised, and so entering into the finest branches, will be found to be a really

rational method, the antiseptic effect here not being diminished by the circulation.

(3) Subcutaneous injections of ferrum lacticum (1 per cent.) in cases of obstinate anæmia or chlorosis.

(i) Anæmic girl, æt. 20, treated for six months with internal ferruginous medicaments, without success; after ten injections red-coloured cheeks.

(ii) Lady, æt. 25; very anæmic; ferruginous medicaments and water useless; after twenty injections coloured cheeks, &c.

Injections being sometimes painful, they ought to be mixed with cocaine.

(4) *Spasmodic convulsive affections*, by which I mean chololithiasis, asthma, epilepsy, and whooping-cough; though these affections do not seem to have anything in common, being different in their origin, asthma and epilepsy sometimes breaking out without any organic cause, while chololithiasis and whooping-cough are occasioned by grave organic or infectious alterations, yet finally they reveal themselves as an expression of cerebral irritation, whooping-cough, asthma and chololithiasis attacking the deeper vagus regions, whilst epilepsy is more concerned with the superficial motor centres.

## SOME OBSERVATIONS ON THE MODE OF ORIGIN OF NASAL POLYPI. (a)

By EUGENE S. YONGE, M.D. Edin.,

Honorary Assistant Physician, Manchester Hospital for Consumption and Diseases of the Throat.

THE central idea, in this investigation, was to endeavour to find some of the processes which immediately preceded polypus formation, and to trace the progression of the disease from normal mucous membrane up to the fully-formed "growth." Observations were made both on the cadaver and on specimens obtained from clinical cases.

The cases from which specimens were obtained for microscopic examination, or which were otherwise investigated, may be divided as follows:—

1. *Cases in which the Nasal Tissues were not Diseased*.—Obtained post-mortem. Fœtus, infant, young adult, &c. Also mucous membrane from all the accessory sinuses.

2. *A Case of Early Nasal Polypus*.—No accessory sinus disease. Obtained post-mortem.

The outer walls of both nasal cavities were examined, and a number of sections were cut in successive antero-posterior planes.

There was a condition of chronic inflammation of the various turbinal and meatal tissues, with the exception of the inferior meatus, which was practically normal. The mechanical process of polypus formation could apparently be traced from smooth (non-polypoid) mucous membrane to structures which showed the characteristics of ordinary mucous polypi. The tissues were œdematous in the areas generally selected by mucous polypi for their site of origin, and the vast majority of the mucous glands were degenerate and dilated. Other appearances, such as enormously thickened vessels in the middle and inferior turbinal regions, were also noted.

It was further observed that polypi appear to

owe their shape, their number, and other characteristics principally to the manner of the initial process of their formation—*viz.*, œdema of the mucous membrane of the part affected, which, in a normal condition, is folded. These folds, when œdematous—that is to say, when sharing in the general œdema of the mucous membrane—gradually assume the appearance of blunt, finger-like processes which correspond in structure to incipient mucous polypi.

3. *Clinical Cases of Nasal Polypus, at various stages*, in which certain of the tissues were examined.

These included (a) polypi associated with accessory sinus suppuration; (b) polypi not so associated; (c) tumours having a similar macroscopic structure to the usual mucous polypi, but growing from the inferior turbinal.

The groups (a) and (b) seemed to have a similar mode of origin. Cystic degeneration of the glands was more marked in the sinus polypi than in the other variety, whilst simple fatty degeneration was observed in both. The inferior turbinal polypus differed from the middle turbinal and meatal polypus in the same manner as the histological structures of the parts differed from each other, so that the former variety was composed of a much firmer, thicker and denser tissue. Dilated glands were observed in both.

4. *Cases of Chronic Inflammatory Conditions of the Nose unattended by Polypus*.—Chronic catarrhal rhinitis may be taken as a type. The conditions observed in the middle turbinal and meatal regions—which may be regarded as the usual sites of polypi—differed from the appearances seen in the same regions when polypi were present in an early stage, chiefly in the following particulars:—

(i) A mucous membrane which, especially in its superficial (sub-epithelial) layer, was not œdematous.

(ii) Active glands as opposed to degenerated and dilated glands. In a few instances, cloudy swelling was noted in a few glands in the section, but usually they were normal.

On the other hand, the instances of chronic catarrhal rhinitis resembled those of polypus, in all the signs of chronic inflammation, and, so far as the writer could judge, in every other condition except in the two respects noted above.

5. *A Case of Chronic Atrophic Rhinitis*.—Obtained post-mortem.

6. *Instances of "Polypus" in other Parts of the Body* (stomach, uterus, rectum, and middle ear).—The writer's observations seem to point to the conclusion that the excrescences which are found in the stomach, in the rectum, and in the middle ear, and which are generally classed as "polypi," have one point—the name—and occasionally a second—the shape—in common with nasal polypi, but that otherwise they differ radically from the growths found in the nose. In polypus of the cervical portion of the uterus, however, there is a close resemblance in structure to the corresponding condition in the middle turbinal region, except that in the former the tissues are somewhat less œdematous than in the latter.

Aural polypi are composed in every instance of ordinary or, later, of organised granulation tissue (Lake); and their structure is, consequently,

(a) Read at the Annual Meeting of the British Medical Association, held at Oxford, July, 1904.

fundamentally different from nasal mucous polypi, properly so called.

*Provisional Conclusions.*

As a result of his observations, the writer suggests the following conclusions:—

1. Mucous polypi of the nose, in the large majority of instances, are consequent upon inflammation of the mucous membrane of the nasal cavity.

2. The process of polypus formation is partly mechanical and partly degenerative.

3. The primary process is a localised œdema of the inflamed mucous membrane, which œdema, chiefly on account of certain known structural peculiarities of the lining membrane, does not, in the greater number of cases, occur in any intranasal area, but that of a limited portion of the middle turbinal and of the middle meatal regions. Analogous structural peculiarities are present in the mucous membrane of some of the accessory tissues.

4. The determining cause of the occurrence of the œdema, in the regions specified, is the degeneration and dilatation of the mucous glands. The following evidence appears to be in favour of this: (i) The abundance of degenerated and dilated glands in the mucous membrane subjacent to and in the immediate neighbourhood of polypi. (ii) The definite and proportionate ratio between the amount of glandular degeneration and the amount of œdema. (iii) The presence of abrupt and isolated patches of œdema, which exactly correspond with isolated groups of underlying degenerated glands. (iv) The presence (in some sections showing two surfaces of a turbinal) of œdema on one side and firm non-œdematous tissue on the other—the œdematous side being supplied with degenerated glands and the firm tissue with active glands. (v) The absence of œdema (a) when the glands are healthy and, generally speaking, in the areas where there are no glands present; (b) in cases of chronic rhinitis where the glands are not degenerated. (vi) The concurrence of this sign in both varieties of polypus ("sinus" and "non-sinus" polypus). (vii) Lastly, the possibility of explaining the œdema, on the hypothesis of these glandular changes, on account of the peculiar arrangement of the glandular blood-vessels, combined with the peculiar histological disposition of the tissues in which the glands of the "polypus regions" lie.

5. The peculiar shape and some other characteristics which polypi assume is due to their mechanical inception as œdema of the normal folds of the mucous membrane.

## THE CARE OF CHILDREN'S MOUTHS. (a)

By SIDNEY SPOKES, M.R.C.S., L.D.S.

AN examination of 10,000 children of an average age of twelve years showed that only 15 per cent. had sound teeth. Dental caries must be regarded as the most frequent departure from the normal physiological standard. Periodical inspection and early treatment are the best methods in default of absolute prophylaxis. Especially should the first permanent molars receive attention. They are situated in the jaws where the functional capacity is greatest. They "keep up the bite" at the back of the mouth during the transitional

period from the temporary to the permanent dentition and should be carefully watched from the seventh year upwards. It is rare to find caries of the other permanent teeth before the twelfth year. A periodical inspection also allows of the opportunity for observing any commencing irregularity in position which itself threatens to promote decay, and it also enables an opinion to be formed as to the extent to which the tooth-brush is properly used. In many parochial schools this system of inspection and early treatment is now carried out with good results, and as it appears probable that Board School children will soon be medically inspected, it is to be hoped that they may also receive dental supervision, and in this respect enjoy the same advantages as the children immediately beneath them in the social scale. Boys in the great public schools should pay a visit to the dentist early in the holidays in order to allow sufficient time for any treatment which may be found necessary, but it is well that there should also be an officially appointed dental surgeon on the staff of all such schools to examine and report upon the teeth of new arrivals and to deal with any cases which may occur through neglect and urgency. This prompt treatment of early caries prevents a vicious circle being established through the increased acidity of the mouth which accompanies untreated cavities of decay and thus promotes decay in other teeth as yet unaffected. Here again, it is most important that cavities, if existing, should be discovered and treated in the early stage. If a tooth has "ached" through irritation of its pulp the best time for stopping the cavity has already passed, but by prompt treatment and systematic inspections until adult age is reached it will be found that the tendency to decay seems in many instances to become considerably less.

## Clinical Records.

### CASES IN HOSPITAL PRACTICE.

By JOHN W. MARTIN, M.D.,  
Hon. Medical Officer, Jessop Hospital for Women, Sheffield.

*Bad Hæmorrhoids.—Severe Bleeding with and between Motions.—Retroflexed and Retroverted Uterus.—Both Ovaries enlarged, cystic; prolapsed.—Operation.—Recovery.*

C. H., æt. 37, married, four children, the last æt. 4. Notes taken May 24th, 1904.—This patient first came under my notice in the autumn of 1903, when she was suffering severely from piles and a constant loss of blood with and between the motions. She was worn to a shadow and very anæmic. She had seen no periods for four years. I operated upon the piles with clamp and cautery, and she made a good recovery, the operation being successful for the object in view.

She had then retroflexion of the uterus, and both ovaries were enlarged and prolapsed. The rest in hospital whilst under treatment for the piles seemed to relieve her of a good deal of her pelvic troubles, pain in the back and iliac regions.

She again came under my care in the early part of May, and was admitted into hospital. She could not wear the pessaries with which an attempt was made to retain the uterus in its proper position. There was both retroflexion and retroversion present. The ovaries were both much enlarged and prolapsed, and very tender to pressure. Suffering a good deal from pain in the lumbar, hypogastric, and iliac regions. The pains extended down the legs. She had suffered a good deal from diarrhoea before she came in, but the bowels became constipated after admission. Her general health was very poor.

(a) Abstract of Paper read in Section of Dental Surgery, British Medical Association, Oxford, July, 1904.

As she could not wear an instrument, and as treatment had been tried for some time before admission, I operated on Friday, May 27th, 1904. I found both ovaries very much enlarged and cystic, and removed them. I did a ventro-fixation. The patient made an uneventful recovery.

July 20th, 1904.—I saw the patient to-day. She is looking much stronger and better. She is putting on flesh. She is quite free from pain, and feels cheerful and active, and says that it is years since she felt so well.

## British Health Resorts.

### V.—TEIGNMOUTH.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

TEIGNMOUTH is "the first of the true West Country ports." (a) It is admirably situated at the junction of the picturesque estuary of the River Teign with the English Channel. The greater part of this attractive little town of 8,540 inhabitants lies open on the east to the sea. On the north and north-west it is sheltered by the heights of Haldon. It is well equipped with sea coast promenade, pier, lawns and walks. Not only is it linked to the past (b) by memorable associations, but forms a delightful centre for the requirements of the present. (c)

Dr. F. Cecil H. Piggott, the present M.O.H., has furnished us with valuable details concerning much that makes for the well-being of the health seeker. The birth-rate is 15.5; the net death-rate 17.08, but allowing for the mortality of non-residents is only 15.45; the zymotic death-rate is 0.58; the infantile death-rate, however, is 127.82. The water supply until recently has been "intermittent and somewhat limited." (d)

An agreement has now been arrived at with the Paignton U.D.C., whereby a constant supply of pure water will be brought from Dartmoor. Efforts are being made to secure a greater degree of purity of the Teign estuary.

The meteorological returns throw much light on climatic conditions. The mean temperature of the past year was 51.5; the mean temperature for the past thirty years, as taken from the records of Dr. W. C. Lake, was 50.6; the maximum temperature was 77.1; the minimum 26.0; the rain fall for 1903 was 40.07 inches, but eighteen years' average is given as 34.8, with 156 as the number of wet days.

Teignmouth is a particularly desirable holiday resort. It offers opportunities for excellent and safe bathing, boating, fishing, and the usual delights of a marine residence. It is a remarkably convenient centre for railway, steamer, driving and walking excursions. The proximity to the bracing highlands of Dartmoor should be remembered. Access to Torquay and other well-known Devon resorts is easy, and the Dart can be readily reached. (e)

It will be seen that Teignmouth, while principally appealing to the town dweller seeking recuperation and restoration and relief from the rush and worry of a wearing life, can also offer much that is desirable for the convalescent and the invalid. High, cold and dry east winds are said to prevail in the spring, but even then protection can be afforded by the sheltered "coombes." The hotel accommodation is somewhat limited, but there are numerous apartments suited to the requirements of the health seeker. For cases desiring a bright, warm, picturesque South Coast

(a) "Highways and Byways in Devon and Cornwall." By Arthur H. Norway. London: 1898.

(b) "Teignmouth: its Past History and Present Interests." By Beatrix F. Cresswell. London: The Homeland Association. 1901.

(c) See "South Devon and South Cornwall." By O. S. Ward and M. J. B. Baddeley. London: 1902. Black's "Guide to Devonshire." London: 1898.

(d) "The Climates and Baths of Great Britain." Vol. I. London: 1896.

(e) Consult *Devonia*, the official organ of the United Devon Association. July, 1901.

marine resort with opportunities for enjoying much variety in out-door life, Teignmouth is most suitable. In summer the place is frequented by children and holiday-makers, and there is much to attract those who need to be "taken out" of themselves. Teignmouth is some 209 miles from London. Comfortable through carriages run from Paddington on the G. W. Railway in about five hours. Access may also be had by the L. & S. W. Railway, Waterloo to Exeter, in three and a quarter hours, and thence over the G. W. system. There are now excellent arrangements for travellers from the North by means of the Midland and London and North-Western railway systems.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, August 7th, 1904.

### TREATMENT OF PHLEBITIS.

THE treatment of phlebitis, says Dr. Huchard, is one of the questions which particularly interests practitioners. Death by thrombus is rather frequent in the first stage, before even the diagnosis of the affection can be made; consequently, it is at this period that rest should be enjoined. In every woman recently confined, in every patient recovering from an infectious malady, or even outside these conditions, every pain felt in the inner part of the thigh, in Hunter's canal, beneath Poupart's ligament, or in the calf of the leg, especially if the pain is accompanied with a sensation of weight and impotence, increasing in the upright position, demands an attentive examination of the principal venous trunks of the limb. The slightest œdema or cylindrical induration, or even a smart pain on pressure over the course of the vein, should make the attendant suspect the existence of phlebitis at the obliterating period, and without waiting for further developments he should not leave the patient before placing the limb in a position of absolute rest.

Let us suppose one of the most ordinary cases—one limb alone is affected. A series of sufficiently hard cushions should be procured, with which is formed a perfectly even inclined plane. A sheet doubled two or three times is placed on the cushions so as to form a good splint, over which is spread oilskin or mackintosh, and on this a layer of cotton wool large enough to completely envelop the limb. The leg is laid gently on this cotton and covering, and when well enveloped a bandage is applied.

With this apparatus, complete extension should be adopted for fear of subsequent stiffness of the joints; the sole of the foot should be supported by a vertical board and the weight of the bedclothes kept off the toes.

As local treatment, concentrated solution of hydrochlorate of ammonia as compresses has given but little result. It is otherwise with certain sedative oils, belladonna, hyoscyamus, &c. They should be renewed three times a day and covered with oilskin.

As general treatment, the tincture of hamamelis virginica, five or six drops twice a day, and continued for months, will be of some benefit and encourage the patient. Collargol spread on as an ointment (15 per cent.) can be employed in infectious phlebitis. Against pain in phlebitis of rheumatic origin M. Oddo recommends aspirin in doses of 30 to 40 grs. daily. Veronal, 10 to 12 grs. at night, exercises a sedative action on the cramps. Valerianate of ammonia or the bromides calm the nervous excitement, and if the œdema is very considerable salt should be proscribed.

The duration of the forced immobility depends on the state of the clot. From the sixth day the clot is



solidly attached to the wall of the vein, but frequently other segments of the veins are seized, and although pain be absent the temperature rises. Consequently, from the first stage of phlebitis the temperature should be taken morning and evening, for the slightest rise will indicate fresh trouble. The patient will not be allowed to move the leg before the twenty-first day after the last rise of the temperature.

At the same time that mobility is allowed, massage commences, at first exceedingly light, and far from the affected veins. After eight days, the massage may be a little more pronounced so as to encourage the circulation in the collateral veins, and thus act on the œdema. At the same time slight movements are permitted, commencing first in the toes, then in the ankle, and eight days after in the knee, but flexion on the thigh cannot be allowed for a long time as any motion in the hip is very dangerous as regards thrombus.

At the end of from twenty to thirty days of the treatment, the patient may quit the bed for a reclining chair and a fortnight later he can stand up; but the leg must be bandaged with a Velpau bandage.

A cure at Bagnoles de l'Orne will terminate the treatment.

#### TREATMENT OF BLEEDING PILES.

The following will be found very effective:—

Chloride of calcium, chemically pure, 2½ drachms;  
Water, 3½ ounces.

Injection into the rectum of five drachms by means of a small rectal syringe. The hæmorrhage ceases in a few hours.

Prof. Boas, who has treated twenty-five patients with this solution, recommends it strongly. The injection may be repeated if necessary.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 7th, 1904.

#### PHYSIOLOGICAL CATALYSORS IN TREATMENT.

At the Naturforschers meeting Poehl gave the members a long dissertation on the physiological catalysors as a means of cure in the practice of medicine. He first commenced with the process of nutrition, which, he said, depended upon, and was preserved by this very natural process. A certain amount of material is taken into the body, and must remain a given time to admit of this catalytic influence in order that the necessary energy may be developed to invigorate and support life. He divides the catalysors into two principal groups, *viz.*, "positive" and "negative," or, in reference to the body, "general" and "specific"; the former influencing the whole of the body, while the latter only affects a single organ. The positive includes all the catalysors that stimulate the organs and tissues to greater activity, while the negative repress or inhibit the action of special organs, of which he gave as examples spermin (positive) and adrenal (negative). Spermin hastens the oxidising process or respiration of the tissues, which neutralises or destroys the depressing properties of the leucomaines. Adrenal, on the other hand, is a reducing catalysor, and becomes a dangerous toxin when carried into the circulation.

It is only recently these catalysors have been acknowledged as therapeutic agents, and are yet in a very premature state for general use. Those in use may be described as special catalysors and directed towards a special organ, whose functions or tissue change it is desired to alter. Those for therapeutic use he would designate as the synergetic group, in opposition to the leucomaines, such as cerebrinum, extracted from the

grey matter of the brain; thyroïdinum, from the thyroid gland; ovarinum, from the ovaries; mamminum, from the breasts, &c. Thyroïdinum catalytically affects the fat, skin, and nerve system; cerebrinum affects the excretions or metabolism depending on nerve changes, and exhibits its beneficial effects in cases of epilepsy, neurasthenia, and alcoholism; ovarinum is useful in the climacteric period; and mamminum in uterine fibromata as well as some other female diseases.

• The negative catalysors are not yet recognised sufficiently to define their therapeutic value. These comprise the toxins, among which the plasma toxin is a good example. The latest observations of Professor Tarchanoff, that these organo-therapeutics all contain a large amount of radio-activity, were further established by Poehl's own personal experience.

■ In the discussion that followed, Naunyn said that he would like more evidence on this hypothetical subject before advancing a dogma on any of the questions put forward, particularly in the reducing property of urine on photographic plates after the use of adrenalin, as well as the general effects of the leucomaines. The action of Poehl's isolated substances on the organism was not to his mind sufficiently proved.

Klemperer said that he had never observed the blood becoming more alkaline after the use of spermin, which would of necessity result according to Poehl's theory.

Poehl, in his reply, would not accept Klemperer's logic, firmly believing, as he did, in his own hypotheses.

#### THE PEST INFECTION.

Schottelins expressed himself as opposed to the generally accepted term that the pest was transmitted through the atmosphere, and took its origin from the lungs. He was firmly convinced that the pest was transmitted by local wounds taking up the infection, and thus transmitting it to the circulation. Scratches, abrasions, or slight fissures of the mucous membrane are fruitful sources of infection. He presented a few wax models he had taken while resident in Bombay to prove his assertions. All of them had some primary centre through which the poison had passed—sometimes the skin, sometimes the mouth, and others in the isthmus faucium. Slight abrasions on the mucous membrane were not uncommon. From the deeper cervical glands the infection is conveyed to the lungs, which gives rise to the doubt as to origin. Again, the white race is immune to the pest virus, as witnessed by the number of European doctors, nurses, and visitors that never take the disease, though dangerously exposed to the virus. The general condition of health and individual social hygiene are potent factors in its distribution, as the underfed and unclean are the first to suffer.

Kraus remembered a case of this nature that impressed him. A slight reddening occurred, causing a running from the nose, and finally malignant diphtheria with bubos in the neck, which confirmed the diagnosis as one of bubonic plague.

Rumpf concurred with Schottelins that the virus was easily taken in by the isthmus faucium.

Rumpel said that he had attended forty cases of bubonic plague in Oporto, and never could discover a primary lesion through which the virus could be conveyed to the circulation.

#### ANTISTREPTOCOCCUS SERUM AND RHEUMATISM.

Schmidt gave a history of fifteen cases which he had treated with antistreptococcus serum with varying success. Eight of these were subacute that had resisted all other treatment, four were acute, and three chronic. The injections consisted of 15 to 20 cubic centimetres daily for eight days. The injections were

used over the affected joints, causing reddening, swelling, erythema, &c., in proportion to the rapidity of action, and no injurious effects were observed. In six cases locomotion was early restored; in four the subjective symptoms were improved, while five had no change. He cannot say there was any specific action, but thinks that the treatment is adapted for the sub-acute cases when other remedies fail.

Kraus agreed with Schmidt in this opinion, as the greatest benefit is observed where it releases the movements of the limbs.

#### CHRONIC INTERSTITIAL PNEUMONIA.

Damsch gave a history of four cases of interstitial pneumonia having no fever or trustworthy symptom to herald its approach. Tubercle was excluded. There was no shrinking of the pulmonary tissue, only the hardening over the affected part. The consequent danger of these cases lies in the twisting of the heart and producing functional insufficiency.

Litten said that he had also met with such cases without fever, bronchiectasis, or shrinking.

Rumpf had seen such cases, but tubercle usually commenced to develop later at one of the apices.

### Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, August 7th, 1904.

At a recent meeting of the Budapest Interhospital Association, Dr. Temesváry Rezső reported a case of DYSMENORRŒEA SUCCESSFULLY TREATED BY ELECTRICITY.

A single woman, *æt.* 23, who began to menstruate normally at fourteen, at nineteen commenced to suffer from dysmenorrhœa, without any cause except slight anæmia. For the last four years menstruation had been irregular and extremely painful, with frequent menorrhagic crises. For the last two years she had had to stay in bed for several days at each period, and morphine injections were necessary. Ordinary medical and gynecological treatment—drugs, local injections, mechanical dilatation of the cervix with curettage of the uterus and massage—had been tried without permanent result. The patient was very anæmic, hæmoglobin being 60 per cent. below the normal. All the pelvic organs except the uterus were normal. The cervical canal was tortuous and stenosed. After fifteen applications of the constant current twice a week for ten minutes, the tortuosity and stenosis of the cervical canal disappeared, and menstruation became regular and free from pain.

Dr. Waldmann Béla read a paper on the prevention of recurrences in

#### SYPHILITIC DISEASES OF THE EYE.

By the following treatment recurrence in syphilitic ocular disease, he had found, could be prevented: (1) In syphilitic disease of the choroid, mercurial inunction should be undertaken for two years, the place of inunction being varied daily. (2) The dose should not exceed 30 gr., and according to the age and constitution of the patient doses of 8 gr. or 15 gr. are better. After every ten inunctions a pause of four days may be made. The best basis for the mercurial ointment is lanolin. (3) Longer pauses than three weeks should not occur in the whole two years. A pause of three months completely nullifies the treatment. (4) Potassium iodide has no curative influence on ocular syphilis, but is directly injurious on account of the conjunctivitis to which it predisposes, and should accordingly not be given in the majority of cases. Potassium iodide has only one use in the treatment

of ocular syphilis, namely, to counteract the injurious influences of large doses of mercury.

#### THE RADICAL TREATMENT OF ULCERS.

Dr. Frater Trure says that though some ulcers on the leg heal with almost any dressing, as iodoform, airol, or xeroform, the greater number resist such treatment, or, if they heal, quickly relapse. For such, skin-grafting after thorough disinfection of the ulcer is by far the best local treatment, but whenever extensive varices are present this is also unsatisfactory. The only radical treatment in such cases is to ligature the saphenous vein according to Trendelenberg's method before proceeding to the transplantation of skin.

Siegel related a case of

#### PRIMARY SARCOMA OF THE SMALL INTESTINE.

A boy, *æt.* 3½, had suffered for three months with symptoms of obstruction, which occasionally alternated with diarrhœa. As a tumour could be felt in the ileo-cæcal region intussusception was diagnosed. Laparotomy was performed, and a hard nodulated tumour was found on a coil of jejunum. The mesenteric glands were enlarged. The tumour and 12 inches of the small intestine were resected. The child died three weeks later with general metastasis, which had involved the pancreas. A small collection of pus was found near the site of the sutures, but there was no peritonitis. The tumour was a small round-celled sarcoma, and had probably started from the lymphatics of the sub-mucosa.

These tumours are rare, the writer having collected thirty-four cases; the greater number occurred in males. The case is chiefly interesting because it is opposed to the usually accepted view that absence of obstruction is characteristic of intestinal sarcomata. They give rise neither to pain nor tenderness.

## The Operating Theatres.

### ST. MARY'S HOSPITAL.

RICHTER'S HERNIA SIMULATING CHRONIC INTESTINAL OBSTRUCTION.—Mr. WARREN LOW operated on a woman, *æt.* about 55, who had been sent up to the hospital by Dr. Alfred Benson. There was a history of the patient gradually getting thin for several months, and having attacks of pain in the abdomen. Some four days before admission the pain was very much worse, and she vomited. The vomiting continued off and on till she came to the hospital, but the bowels were opened with enemata the day before admission. On admission she was feeble, but not collapsed; the vomiting was fecal; under the thin abdominal wall were seen hypertrophied coils of intestine along which occasionally a peristaltic wave passed; there was no tenderness, and nothing could be felt *per rectum*. Although she had worn a double truss for some years, no lump could be felt in either groin, and the woman said neither of the herniæ had been down for some years. The abdomen was opened in the middle line, and underneath the incision were found congested and distended coils of small intestine, of which the muscular coats were obviously hypertrophied. On passing the hand into the right iliac fossa, the cæcum was found collapsed, as were also the lowest coils of the ileum. These collapsed coils were examined, and at the distance of some three or four feet from the ileo-cæcal valve a coil of intestine was found to be apparently attached to the abdominal wall in the region of the right internal abdominal ring: a further examination showed that part of the lumen of the bowel was tightly constricted in the aperture.

With a little difficulty this was carefully disengaged and brought out of the abdominal wound. A ring of ecchymosis demonstrated the actual area of gut involved, constituting about two-thirds of the lumen. The strangulated gut was elastic and began to gradually recover its normal appearance, and was obviously in a condition to return to the abdominal cavity; moreover, the gas in the distended coils began to find its way past the constriction and the coils hitherto collapsed were now distended with gas. The intestine was returned and the abdominal wall sewn up. Mr. Low said that the case was interesting as it illustrated a fact of which several examples had occurred lately at St. Mary's of the often insidious onset in these cases of partial hernia. This woman was not in the least collapsed and the obstruction could not be called absolute till the day before admission, although she certainly was suffering from a strangulated hernia, and, in fact, with her history, she presented all the appearances of a case of obstruction to the gut by a growth which had suddenly become blocked, her symptoms being those of obstruction rather than of strangulation. Another point, he said, was that the hernia was not demonstrable from the outside, even with one hand in the abdomen at the aperture of the ring. He pointed out that he had to be very delicate in drawing the nipped piece of intestine out of the sac, as he was unable to prophesy in what condition he would find it. This process occupied some minutes and almost necessitated an incision over the region of the hernia. He said a few words of caution as to disengaging a hernia from the abdominal side, as in such a case the constricting neck of the sac had not been divided, as is usually the case in operating in the ordinary way. He had had under his care two or three examples of Richter's hernia; they had all occurred in women. In each case there had been the same insidious origin, and the patients had not been brought to hospital till the hernia had perforated and peritonitis had occurred. Judging by these examples he thought that in quite a large proportion of partial hernia the symptoms were rather those of obstruction than of strangulation.

A week after operation the patient was doing perfectly well; the bowels had been opened and there had been no sickness.

#### The Plague.

THE following telegram from Hong-kong from Governor Sir M. Nathan has been received at the Colonial Office:—"Seventeen cases of bubonic plague, 17 deaths, for week ended July 30th."

Oxford: Doctors at St. Aloysius.

ON Tuesday, July 26th, a special service was held in this church for the benefit of Catholic doctors attending the meeting of the British Medical Association. Some twenty or thirty medical men were present, including the President of the Irish College of Surgeons, who wore his robes. During the Mass, the choir boys, assisted by the young ladies from St. Ursula's Convent, sang very tastefully an appropriate selection of hymns. Father Arthur Day, S.J., delivered a short discourse, basing his remarks on the text of St. Paul: "Knowledge puffeth up: charity edifies." The dignity of the medical profession, as distinguished from that of the veterinary surgeon, rests on the admission of the immortality of the human soul. A materialist doctor must often in kindness hesitate to prolong human misery. Science is very necessary to surgeon and physician, but without deep religious belief neither can rise to the full nobility of his vocation. Learning alone is apt to inflate; animated with supernatural charity it becomes a powerful engine for good; and the Christian doctor almost an apostle.—*Tablet*.

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## The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 10, 1904.

### THE CHLOROFORM COMMITTEE REPORT.

THE British Medical Association do well in employing some of their resources for the furtherance of general scientific knowledge, and there is certainly no question that they could undertake to investigate with more hope of practical benefit than that of the dosage of chloroform. A Committee was appointed three years ago to examine the subject from different points of view, and their third annual report has just been issued. The previous researches of various observers on the action of chloroform have produced varying results, and whilst week after week reports of deaths from chloroform anaesthesia continue to come in, the profession cannot but feel their position in the matter to be an invidious one. Although the employment of ether and some of the newer bodies has rendered the use of chloroform less generally needful, it must nevertheless be borne in mind that not a few deaths occur under ether, while none of the new anaesthetics is absolutely safe. There remain a number of cases in which chloroform is still indispensable, and from the patient's point of view it is by far the pleasantest anaesthetic to take. For a long time past the comment has been made in various quarters that whilst the dosage of drugs is rigorously respected and enforced by medical men, yet when they deal with a highly dangerous medication, such as chloroform vapour, they administer an unmeasured quantity to the patient. This comment is not without its force. The only reply that can be made to it is that we are still ignorant of the quantity, or rather the percentage, that can be safely given. The fatal dose, indeed, is usually small. Several instruments have been devised from time to time by which the amount of chloroform administered can be measured, and the weighing of definite quantities of air and chloroform vapour be placed under the control of the operator.

Of these, Krohne's apparatus was the first, and demonstrated the extremely small quantity of chloroform vapour that, judiciously administered, can induce sound anæsthesia. Mr. Vernon Harcourt, F.R.S., a member of the British Medical Association Committee, has, however, devised a more accurate apparatus than any that have yet been put forward, and during the past year he has improved on his original pattern by introducing into it a carefully graduated conical bottle to hold the chloroform. By this means he is able to compensate, by an increased superficial area, for the diminution in the evaporation that results from the sinking of the chloroform in the bottle as it passes into vapour, and throughout the whole administration he can secure that almost exactly the same percentage reaches the patient with the inspired air. Another advantage of his method is that the rate and depth of respiration have hardly any appreciable effect on the actual quantity of chloroform inhaled, as in rapid respiration, although more air passes over the chloroform, it takes up less of the anæsthetic, whilst in slow, deep breathing the opposite is the case. It remains to be shown that chloroform administration will be rendered safer by the employment of graduating apparatus, the use of which, we believe, has not been unattended with fatal results. Side by side with the evolution of Mr. Vernon Harcourt's apparatus Professor Sherington and Miss Sowton have been pursuing a series of investigations into the action of chloroform on the isolated mammalian heart. The report of their work deals with experiments in perfusing the heart with small doses of chloroform in various solutions, and contrasting the effects thus produced with those wrought by similar doses exhibited in blood. Comparing the action on the heart of chloroform in saline solution with the action of chloroform in blood they found that the depressant effect of the latter was only one-twelfth that produced by the chloroform in saline solution, and also that when the quantity of chloroform was increased permanent damage to the cardiac muscle resulted much earlier when the anæsthetic was exhibited in saline solution than when exhibited in blood. Very interesting to compare with these conclusions are those arrived at by Mr. Byles, Mr. Harcourt, and Sir Victor Horsley, who undertook the work of estimating the effect of chloroform on the blood itself. Briefly summed up, their conclusions are that blood has a specific power of retaining chloroform, and that it is in the corpuscles, not in the plasma, that this ability resides, but that it is necessary for the corpuscles to remain intact if they are to keep this power. The amount of chloroform retained by the corpuscles was about 20 per cent., and thus it is obvious that the anæsthetic must have far-reaching effects on all the fixed tissues. Perhaps, however, the most important of the whole series was the closing experiment on a dog, anæsthetised by means of Mr. Harcourt's inhaler, from which quantities of blood were withdrawn at intervals, whilst the amount of chloroform was gradually increased

to the lethal point. Without going into all the details, it may be said that the quantity of chloroform in the blood at the time of death was almost exactly twice that found in the blood at the moment that anæsthesia was complete. We hope that this experiment and similar ones on other animals will be repeated, for it shows how small a margin exists between safety and danger. Dogs are notoriously susceptible to chloroform poisoning, and results obtained from experiments on them by no means apply equally to man, but anything that can throw light on the limits of safe chloroform administration is greatly to be welcomed. We trust, therefore, that the Committee will be able to pursue its labours for several years, as it can hardly be expected that the full facts will be established without a long period of hard work. If in the end the Committee are able to demonstrate how chloroform fatalities can be avoided, they will earn the gratitude of all their colleagues.

#### THE LORD CHANCELLOR AND THE MEDICAL PROFESSION.

OUR readers will remember that more than once during the past year or two we have had to comment on the attitude one of the London coroners has seen fit to adopt toward the general practitioners in his district, and the manner in which he is in the habit of exercising his public duties. As the facts must be already known to our readers, it is sufficient to recall that it is the custom of Mr. Troutbeck, the coroner in question, in conducting inquests, to ignore as far as possible the evidence of practitioners who had attended the deceased during life, or who had been called in immediately after death, and, further, whenever a *post-mortem* examination has been thought necessary, its conduct has been committed to one individual practitioner who has no claim to be considered a pathological expert. In many cases where valuable clinical evidence could have been brought forward, it has not been obtained, and verdicts have been returned on evidence obviously incomplete and insufficient. It is more than twelve months since, having failed to obtain any satisfaction from Mr. Troutbeck himself, four well-known medical societies—the British Medical Association, the South-West London Medical Society, the Medical Defence Union, and the London and Counties' Medical Protection Society—united in sending a joint deputation to the Lord Chancellor to draw his attention to the manner in which Mr. Troutbeck exercises his magisterial functions. They presented a terse memorandum embodying their views, and supported it by reference to several specific cases. This memorandum was then submitted by the Lord Chancellor to Mr. Troutbeck, and a copy of his observations thereon was transmitted to the Medical Societies, but no expression of the Lord Chancellor's opinion was given. The medical societies then formulated a detailed criticism on Mr. Troutbeck's observations, and sent it to the Lord Chancellor, receiving in

return a formal acknowledgment from his secretary. During the past twelve months his Lordship's attention has further been called to several cases as they occurred, in which Mr. Troutbeck either neglected material evidence, or went out of his way to attack medical men who had not been summoned to attend. Up to the present, however, the Lord Chancellor has refrained from committing himself on any of the points put before him. His Lordship should remember that high as is the dignity appertaining to the office he holds, that dignity only belongs to himself in so far as he fulfils the duties of his office. He is, like many humbler persons, as far as the performance of his public duties go, a servant of the State, and one of the most important of these duties is the supervision of the performance of their functions by the magistrates of the land. In the present instance various charges have been laid against one of these magistrates, the Coroner for Westminster, and his defence has been heard, but both complainant and defendant are still, after twelve months, waiting for a decision. Under the circumstances the only course open to the Medical Societies is the one they have taken, to publish the entire correspondence. The British Medical Association, however, has advanced matters by furnishing the Lord Chancellor with a carefully drawn statement of proof of all charges made against Mr. Troutbeck, together with a distinctive analysis of that gentleman's defence and counter-charges.

#### THE IRISH POOR-LAW MEDICAL SERVICE AND ITS OLD FRIEND "THE MEDICAL PRESS AND CIRCULAR."

A REMARKABLE letter appears in the columns of our contemporary the *Journal of the Irish Medical Association*, from the pen of Surgeon-General Evatt, on the subject of the organisation of the Irish Medical Association. Surgeon-General Evatt has recently visited Ireland as special commissioner of the British Medical Association, and has embodied the result of the information he acquired there in the form of a very long and elaborate report. This report we noticed on its appearance, when we had the greatest pleasure in drawing attention to its many good points, and, we may say, in also refraining from excessive criticism of its weak ones. Perhaps its most curious point was the utter failure to recognise that the majority of the matters to which it called attention in the condition of the Irish Poor-law Medical Service had been already emphasised and brought before the public time after time in the columns of THE MEDICAL PRESS AND CIRCULAR, and that it was to the insistence of this journal that much of the light of publicity which has fallen on Irish Poor-law matters in the last twenty years was due. In short, to judge from Surgeon-General Evatt's report it would appear that no journal other than the organ of the British Medical Association had ever worked for the betterment of the Irish Poor-law Medical Service. We did not at the time draw attention to this curious omission. Surgeon-

General Evatt had been sent over by another journal, and was for the time being its servant, and why should he see good in the work accomplished by a rival even though that work was spread over some half century, and that the disdain of his employers for mere Irish matters during that time was great? His recent letter, to which we now refer, cannot, however, be allowed to pass, in that not content with the mere ignoring of the existence of THE MEDICAL PRESS AND CIRCULAR, it proceeds to make serious mis-statements. We are quite willing to believe that these are the result of sheer ignorance of the facts of the case, but, even if that excuse is made for them, they require correction. "In Ireland," says Surgeon-General Evatt, "when a doctor wants a *locum tenens*, there is now, so far as I am aware, no organised centre to which he can apply by telegraph, &c.," and then he proceeds to recommend that such an office should be established. If Surgeon-General Evatt had not ignored the existence of a journal which is still older than the one he represented, and whose work for the improvement of, and whose knowledge, of the Poor-law Service is and has been immeasurably greater, he would in the course of his visit to Ireland have discovered that such an office has been in existence for many years, a fact that is well known. Again, Surgeon-General Evatt by implication suggests that there is no "Students' Number" published to give the Irish medical student full information, and to warn him of the drawbacks of Irish medical life." We all know what English ignorance of Irish conditions of life is, and what have been its fruits in the past, but, while such ignorance can be excused amongst those who remain at home, it can scarcely be excused amongst those who go abroad to seek information and who consider they have found it. Will Surgeon-General Evatt consult the Students' Numbers of this journal? will he read the advice to the young student that they have contained now for many years? and will he write and inform us whether he still considers that another Irish Students' Number is required? Will he then cast his eye over previous issues of this journal and its special Irish Poor-law Supplement, and will he tell us what he expects to gain by creating imitations? Surgeon-General Evatt hints that a misfortune of Irish medical life is redundancy and want of coalescence, and yet he advocates the duplication of everything that is now done by THE MEDICAL PRESS AND CIRCULAR. Perhaps if he were to go a little more behind the scenes he would learn that all the resources of this journal had been offered to the Irish Medical Association for the special purpose of avoiding duplication, and of furthering the interests of the Poor-law Service; he would thus understand how easy a thing it would be for the Irish Medical Association to make itself a more effective organisation, if it pleased to do so.

THE address on Surgery at the Vancouver meeting of the Canadian Medical Association will be delivered by Mr. Mayo Robson.

## Notes on Current Topics.

### A New Method of Testing the Heart.

A NEW method of testing the functioning power of the heart has been lately presented to the Verein für innere Medizin, in Berlin, by a M. Katzenstein. The information which it affords is said to be of special value in cases in which the heart is about to be subjected to a severe strain, as in certain surgical procedures, and as it is comparatively easy of performance it is worthy of attention. The procedure is based on the observations made on animals to the effect that the ligature of large vessels results in an increased cardiac activity, characterised by a rise in the blood pressure without any change in the pulse-rate. To apply the test, the patient is placed in a recumbent position and, when quiet, the pulse-rate and blood pressure are determined. Compression of both femoral arteries is then made and kept up for from two to five minutes, and then the changes in the blood pressure and pulse-rate are noted. If the heart is acting normally, the pressure causes a rise in the column of mercury of from five to fifteen millimetres, while the pulse-rate remains the same, or is slightly lessened. If the heart is hypertrophied, a rise of forty millimetres occurs, and the pulse-rate remains the same, or is slightly increased. Slight cardiac insufficiency is accompanied by increased pressure, the pulse-rate remaining unchanged or increased. Marked cardiac insufficiency is accompanied by a lowering in the pressure and an increase in the pulse-rate. These results are said to be very constant and trustworthy, and only to be affected by excitement or nervousness on the part of the patient.

### The Position of Gynæcology.

WE are pleased to see that Dr. Haultain, of Edinburgh, has drawn attention in the columns of the *British Medical Journal* to the extraordinary arrangement by which a discussion on hysterectomy came before the Section of Surgery at the recent meeting of the British Medical Association at Oxford. As our readers know, we had already called attention to the anomaly which brought a purely gynæcological subject before the Section of Surgery, and we trust that Dr. Haultain's letter will be a forerunner of further protests. He had expressed the hope that even at the last moment the discussion might be allocated to its proper place, but this was not done. An effort should now be made to determine who is responsible for the arrangements, and how it came about that this slight was offered to the Section of Obstetrics and Gynæcology. If a satisfactory answer is not obtained from the Council of the Association, and an undertaking given that at future meetings gynæcological subjects will be referred to the Gynæcological Section, it would be well for gynæcologists to consider if it is worth their while to support the meetings of the Association.

### Degenerates Again.

DR. F. J. SMITH, who read a paper on "Criminal Responsibility of Homicidal and Dangerous Lunatics" in the Forensic Medicine Section of the British Medical Association, is evidently what would be called in the political jargon of the day, a "whole-hogger." He thinks that we are far too humane to our lunatics, and he would have them destroyed, not by judicial hanging, but by the use of a lethal chamber. Few people will doubt that this is the rational method of dealing with individuals who are not only useless but dangerous. The man Prince, who created such a painful sensation by stabbing the actor, Mr. William Terriss, and was committed to Broadmoor. "during His Majesty's pleasure," signalled his sojourn there by perpetrating a murderous assault on his attendant. What use can it be to a community to preserve a depraved creature of this kind, whose existence consists in playing billiards and, when opportunity offers, killing a useful citizen? The only reply that can be given is that the trend of public feeling is all in the direction of humanitarianism—often mistaken—and that humanitarianism, like religion, is not confined within the bounds of strict ratiocination. Dr. Smith, then, follows Dr. Rentoul in advocating the sterilisation of lunatics, alcoholics, and the victims of other drug habits. Here again it is impossible to argue that his proposals are not eminently sane, but the favour that they are likely to meet with was evidenced by the disposition of his audience at the meeting, where they were generally described as revolutionary and impracticable. Difficult as the solution of these questions is in the present temper of society, it is well that they should be kept to the front, for the condition that allows propagation from the loins of criminals and lunatics of broods of tainted offspring discloses a weakness fatal to its ultimate success.

### Identification.

THE case of Mr. Adolf Beck that has lately been before the public cannot conduce to the feeling of security that is the right of every self-respecting citizen. In 1896 this unfortunate gentleman was sentenced to seven years' penal servitude for a series of heartless frauds on women, and again this year he was arrested, tried, and convicted of similar offences. Fortunately, before sentence was passed, another man was arrested through the exertions of a Mr. Glenville. On further inquiry enough evidence was accumulated to justify an immediate appeal to the Home Secretary for a free pardon for Mr. Beck, and this was granted with commendable promptitude. The prisoner, who has passed under various aliases, somewhat resembled Mr. Beck in appearance, and their handwritings were similar, but the astonishing fact remains that no less than fifteen different women identified Mr. Beck as the man who defrauded them, ten at his first trial and five at his second. In the face of such evidence it is hardly surprising that a conviction followed



in both cases, and it is difficult to attach any blame to the police authorities under the circumstances. In the best regulated States justice must occasionally be led astray; happily in this country its miscarriages are few. Mistakes in identification, when the identification rests in the hands of the police, should, however, be practically impossible at the present day. The wonderful accuracy of M. Bertillon's methods of measuring and classifying features is beginning to be recognised over here, whilst in France all detectives are regularly trained in his system. Besides identification by the pattern of the whorls of the thumb, M. Bertillon has a system of describing the characters of the leading features in a few abbreviated words that is fully sufficient to instruct any detective as to the detailed appearance of a suspect. The combination of all these characteristics puts any reasonable chance of error out of court entirely. The feature on which most reliance is placed is the ear, which is perhaps the most generally neglected characteristic, but all the other points in the appearance, such as the size, inclination, and shape of the nose, the colour and shape of the eyes, and so on, are all included in these "word-portraits," as they are called. The old haphazard rules of thumb that used to govern the police in identification have been superseded by practical applications of the science of anthropometry; we can only hope that Scotland Yard is fully abreast of its latest developments, for accurate identification is the basis of all successful criminal procedure.

#### Execution by Electricity.

AN increasing number of people are to be found who object to capital punishment *in toto*, and it is not altogether unlikely that the lapse of another half century may find public opinion in this country generally opposed to executing criminals. Whether individuals are in favour of its retention or not, all are agreed that the process of destruction should be certain, instantaneous, and painless, although, curiously enough, the mental agony of the condemned man, who is allowed to wait for weeks in his cell after sentence has been passed, is seldom taken into account. The horror of anticipation under this set of circumstances must be immensely more distressing than even the most physically painful execution. The American method of destroying life by passing a strong electric current through the body of the victim was hailed as a great advance on the old-fashioned process of using the guillotine. At the time of the inauguration of electrocution there were reports of difficulties in securing instantaneous death in one or two cases, but the impression generally prevails that with greater experience these difficulties have been overcome, and that the condemned man passes from life to death with unerring certainty when the current is switched on. This, however, is far from being the case. In May, and again in June of this year, instances of failure were reported, the criminal in the former case requiring five shocks, and in the latter three. Various

explanations were put forward to account for these horrible catastrophes, such as that the prisoner was thin, that his skin was thick and oily, or that he was a bad "conductor." The point has been raised in connection with these cases as to whether electrocution does always kill its subjects outright, or whether, as happens in lightning-stroke, the person is not sometimes the subject of profound shock from which resuscitation is possible. If so, the real cause of death in the criminals so treated is the knife of the pathologist who performs the post-mortem. The very idea is so revolting that it may well be hoped that our own antiquated method of execution may not be superseded by any other till at least absolute certainty of result is secured.

#### Dangers of the Drinking Cup.

THE possible perils of the Communion cup from the hygienic point of view have already been discussed in the medical and lay press, and we are glad to think that in many quarters attempts are now being made to cope with the difficulties that surround the introduction of any innovation, however beneficial, into religious observances. But there exists another danger from infection in the use of ordinary drinking cups by school children and others. In the case of the drinking fountains found in public parks and other places it is a wonder that more disease is not disseminated by this means, considering the filthy state of some of those who drink from them. The purity of the original water supply is often thus compromised by individuals who make improper use of the drinking cups, or who are themselves affected by some infectious disease of the face or lips. From the annual report of the Medical Officer of Health for Poplar, Dr. F. W. Alexander, it would appear that the drinking facilities for school children, especially during the present hot weather, are in much need of supervision. He rightly points out that the children themselves cannot be expected to take many precautions, especially those in the younger classes, and he approves of a method adopted by some schools in having the water in the schoolroom, where it is served out by the teachers as occasion requires. It is not a pleasant reflection to think that two or three cups do duty for a school of several hundred children, as has been observed, but now that public attention has been called to the whole question it is to be hoped that such primitive arrangements will no longer be in vogue. The enormous prevalence of impetigo of the face in certain quarters of the metropolis may possibly be accounted for through infection by means of the drinking cup.

#### Popular Medical Phraseology.

THE avoidance of technicalities in the witness-box or in writing a medical report destined for the consideration of the judicial mind is a necessity early impressed upon the student of forensic medicine. Plain Anglo-Saxon terms and phrases are to be preferred under such circumstances rather than the most accurate classical description. To the medically trained mind it appears, no doubt,

far more pathologically correct to describe the consequences of a blow upon the orbit as "an extravasation of blood accompanied with sub-conjunctival ecchymoses" than to express the same in the homely language of the man in the street. Nevertheless, the term "black-eye" and all that it implies is at once understood by those to whom a more scientific description would be absolutely unintelligible. Recent magisterial comments upon the subject of medical phraseology show how important it is not only for medical witnesses to describe symptoms in language that is "easily understood of the people," but also that the wording of medical certificates should be as simple as possible. In the case to which we refer, exception was taken to the use of the word "epistaxis," from which a drunken man was certified to be suffering. The term is certainly more impressive than its English equivalent, but it does not, unfortunately, find a place in police-court parlance. It so happens that this symptom is equally well defined by both the popular and the scientific designation, but there are many other instances in which the use of the Latin or Greek name is infinitely preferable, either on the grounds of propriety or, more commonly, because much wearisome circumlocution is thereby avoided. There are times and places, however, when only one of the two modes of expression is permissible.

#### Milk Supplies.

WE are glad to see more interest being taken, both inside and outside the medical profession, in the all-important matter of town milk-supplies. The subject has been given considerable space in the "dailies," and has formed a topic of discussion at the various summer medical gatherings. Out of the attention thus directed to it, it is sincerely to be hoped that practical schemes will arise to place the whole matter on a satisfactory footing. People have a touching faith nowadays in the power of the legislature to remedy all their evils, but they might well realise that, ready to their own hands, lie many methods far more speedy and far more efficacious. An example of what may be done with regard to improving the milk supply has lately been given by the citizens of New York, who found that, in spite of all the regulations and inspections of the Departments of Health, the milk that reached the houses was foul with dirt and bacteria. A Milk Commission, made up of physicians from the County Medical Society, was formed to offer the dairymen and milk dealers, first, free instruction in the principles of producing clean milk, and secondly, a public guarantee if their conditions were complied with. The practical effect of this guarantee amounted to a condemnation of all non-guaranteed milk, a fact which people soon discovered for themselves. A bacteriologist, Dr. Belcher, was appointed to visit the farms, instruct the farmers, suggest alterations in their premises and methods, and to test the milk. Needless to say, he found a great deal of instruction needed, for some of the farms were as filthy and badly kept as, let us say,

our own. Now that matters are in working order, the milk is regularly analysed, and the conditions of the farms kept under the eyes of an inspector. The milk is sold in two classes, "certified milk," which is guaranteed to have conformed to very stringent regulations, and is therefore rather dearer, and "inspected milk," which is bought with an assurance of having been produced under conditions of strict cleanliness. A self-helping plan of this kind is likely to work well, and we commend the idea to sanitarians on this "side."

#### Newspaper Medical Discovery.

THE correspondent of a leading London newspaper last week telegraphed the news of what he evidently regarded as a marvellous discovery—namely, the cure of some forms of idiocy by thyroid gland. Needless to say, the cure of cretinism by that drug has been well known to medical science for years past. The discovery of the marvellous action of thyroid gland was made by English observers, and is one of which our countrymen may be justly proud. It is somewhat amusing, therefore, to find a presumably well-informed London journal gravely announcing that a Vienna physician has succeeded in bringing cretinism within the category of curable diseases. Following the "bad form" which characterises modern lay journalism in these matters, the correspondent proceeds to publish details of cases thus treated. The incident appears to partake of the ineradicable modern leaning towards things "made in Germany." Surely, it would be more in accord with the imperialistic sense of pride, of which the journal quoted is a strong advocate, were honour given to English medical men where it is due instead of to belated Continental imitators. Why should not a wealthy London newspaper submit medical and scientific stuff to a qualified medical sub-editor?

#### Hospital Amalgamation.

AT a time when the rivalry of the medical charities has well-nigh reached a breaking strain, it is comforting to find two large institutions of the kind coming to a friendly amalgamation. Manchester requires an immense public medical service, owing to the large industrial population. The Victoria University of the city found that the practical requirements for instruction of midwifery were not adequately provided for. The University authorities, therefore, negotiated with the management of two large hospitals, St. Mary's and the Southern, with the result that amalgamation has been resolved upon, subject to the approval of the governors. The newly formed hospital, to be called St. Mary's, will be devoted exclusively to maternity cases so far as the wards are concerned, but it is proposed to establish an out-patient department for diseases of women and children. The principal advantage of the amalgamation is that it allows the provision of a maternity hospital and a training institution in midwifery such as hitherto have not existed. When the amalgamation of the two hospitals is completed

there will be 225 beds available for instruction in midwifery and the diseases of women and children. There will also be a school for the education of medical students, midwives, and midwifery nurses. Another advantage is that all danger of overlapping will be removed, and that the sick poor, for whom the institutions primarily exist, will be further benefited. Thus equipped, the teaching of midwifery in Manchester should be second to none in the United Kingdom. Londoners will note with regret that they possess no institution comparable with the proposed one at Manchester. Their hospitals are all in a condition of fierce rivalry, and any attempt at amalgamation is bitterly resented.

#### Millinery and Science.

THE excellent work of the Sanitary Congress at Glasgow was marked by a new feature, namely, a Woman's Health Conference, presided over by a great Scotch noblewoman. The departure is most praiseworthy, on most grounds, except, perhaps, that which appears to have commended itself chiefly to the attention of a local journal. The following amusing passage, culled from that source, would not be unworthy the attention of our esteemed friend and contemporary *Punch*. (We have suppressed names.) "Her Grace the D— of M—, who presided, wore a black gown, with a bolero trimmed with fine tucks, and relieved by a lace yoke, and by touches of white cord and lace. Her small toque was violet, with a cluster of white flowers. Lady H— G— wore pale grey with flecks of white, and a white silk and lace front and revers. She had a large hat of rose pink, with black plumes. Lady G— C— had a dark blue trottoir costume and bolero, with a hat trimmed with roses and Neapolitan violets. Lady P— was in brown cloth, faced with white, embroidered in brown and red, and wore a brown hat, with cream lace. Mrs. F— wore a pale grey gown, with a black hat, and Miss I— was in black. Mrs. M— wore black and white foulard, with a black velvet picture hat. Dr. E— P—'s blue gown of boucle cloth was smartly strapped with white, and a hat of blue straw with white silk was worn to match. Miss J. E. S— was in pale green, with strappings of fawn and green, Mrs. O— was in grey, with a black picture hat. Mrs. C— M— wore green, with cream lace. Mrs. B— F— was gowned in black, accordion-pleated, and trimmed with chiffon, with touches of rose pink. Black was also worn by Mrs. G—, with white facings, and a black crinoline hat."

#### The Examinations of the Central Midwives' Board.

THE action of the Central Midwives Board in appointing or deciding to appoint unqualified women to examine candidates for registration under the Midwives Act was brought before Parliament last week by Dr. Thompson in the form of a question to the Secretary of State. Mr. Akers Douglas replied that he did not think that the Board had taken such action, but even if they

had he had no power to interfere. In spite of this, we trust that members of Parliament will continue to bring the many unwarrantable proceedings of the Midwives' Board to the notice of the House, as sooner or later the amending Act will have to be passed, and it is well that the necessity for such an Act should be brought home to the Government and the members generally. The decision that the Board should be free to select anyone whom it chooses from, as Dr. Sinclair put it, "a highly gifted chambermaid" upwards, to examine the candidates for its diploma, was made in spite of the protests of several members. With the greatest respect for Dr. Cullingworth's high position in his profession, his action in supporting this decision appears to us to be most wrong, and to be prejudicial not alone to the interests of his own profession but to those of the women who shall present themselves for examination and of the public at large. When discussing the question of examinations, Miss Paget with charming naïveté, asked, "Surely for the first examination you will not be too strict? Surely medical examinations begin gently?" Miss Paget does well to make these requests; she in conjunction with other members of the Board have shut the door in the face of the highly qualified nurse, and have opened it to those who have attended twenty cases under the auspices of any general practitioner. Her protégées will undoubtedly require to be dealt with gently. It is, however, a poor consolation for those who had hoped for an improvement in the "Gamp" to learn that the Board entrusted with the carrying out of that improvement is compelled to deal gently with the incapable because it has seen fit to reject the competent. The nurses who would have presented themselves from the Irish maternity hospitals would not have required any favours from the examiners other than a fair examination. The first examination will be held in May, 1905, but whether it is to imitate the Board itself in its procedure and to partake, as Miss Paget apparently wishes, of the nature of a conversation, is not stated. Subsequently examinations will be held twice a year in London and the provinces simultaneously "or more frequently if necessary," in order, we understand, that the woman who fails at one examination may be able to present herself for re-examination at the earliest date possible.

#### Germ-Laden Railway Carriages.

FOR some years past the sanitary dangers of the unclean railway carriage have been before the public. British minds, however, like the poet's "mills of God," "grind slowly," although in the long run it must be admitted they grind "exceeding small." In other words, the next generation of our countrymen will most likely be provided with railway carriages built upon scientific sanitary methods and systematically cleansed. The rough surfaces and upholstery of our first and second-class carriages form an inviting rest and shelter for unwholesome germs. The scuffle of the foot along the carpet, or a pat on a cushion raises a cloud of

dust that might well make the stoutest sanitarian turn pale. Dust spells disease, especially in a railway carriage, and that form of "matter out of place" has been shown again and again to foster the microbes of consumption and other deadly maladies. In the bare unfurnished type of third-class carriage the chief lurking place of these evil germs appears to be on the rough floor. Why should not railway carriages be furnished throughout with smooth surfaces capable of thorough and efficient cleansing? The filthy condition of many a smoking carriage is nothing short of an outrage on society, which is obtaining some sort of first-standard School Board sanitary reform in other directions. Why should not railway carriages be systematically inspected by some central State authority?

#### PERSONAL.

ON the occasion of the King's recent visit to Liverpool, the loyal address from the University was read to His Majesty by Dr. A. W. Dale, the Vice-Chancellor of the University. Dr. Dale was presented to the King and Queen by the Earl of Derby.

THE Queen has consented to become patron of the Association for Promoting the Training and Supply of Midwives, the object of which is to organise and assist the training of women to act as midwives among the poor, and so meet the requirements of the new Act.

DR. F. F. CAIGER will deliver the Bradshaw Lecture of the London Royal College of Physicians on November 15th, instead of November 3rd, as previously announced.

DR. FREDERICK ROBERTS has been nominated Harveian Orator of the London Royal College of Physicians for 1905.

THE DUCHESS OF MONTROSE presided at a conference of women on hygiene at the 22nd Congress of the Sanitary Institute recently held at Glasgow.

THE Campbell Hospital for Infectious Diseases, presented to the public by Dr. Campbell, Convener of the County of Banff, was, on the 30th ult., formally opened by the Dowager Countess of Seafield.

DR. J. W. E. COLE has become a District Surgeon in the Administration of North-Eastern Rhodesia.

DR. J. M. L. BROWN, Medical Officer of Lagos, has resigned his appointment.

GEORGE MACKAY, M.D., F.R.C.S.Ed., of Edinburgh, has been elected President of the Caledonian Medical Society for the ensuing year.

MR. H. R. JOHNSTON, M.B.Dub., has received a handsome testimonial from the officers and staff of the Infirmary of St. Olave, Rotherhithe, on the occasion of his retirement from the medical superintendship of that institution, a post which he has held for eighteen years.

THE Senate of the University of Vienna has recently celebrated the retirement of Professor v. Vogl on attaining his 70th birthday.

DR. BENTLEY, of Kirkliston, Scotland, has been publicly presented with a horse and brougham for himself, and other articles for his wife and daughter, as a token of esteem from friends and patients.

DR. PRITCHARD, the London otologist, delivered

his valedictory address on August 1st, to the International Congress of Otolaryngology at Bordeaux, and cordially welcomed his successor, Dr. Moure, of Paris.

DR. J. F. PAYNE, the Harveian Librarian of the London Royal College of Physicians, will deliver the FitzPatrick Lectures in the College, on November 8th and 11th. The titles of the lectures will be "Gilbertus Anglicus and Medicine in the Anglo-Norman Period" and "Ricardus Anglicus, and the History of Anatomy in the Middle Ages."

DR. LESLIE has been selected by the Royal University Graduates' Association as a suitable person to be appointed to the vacancy on the Senate of the University caused by the death of Dr. William McKeown. Representations to that effect have been made to the Government, with whom the appointment rests, and they have promised to take them into consideration.

SIR JOHN W. MOORE, late President of the Royal College of Physicians of Ireland, received the honorary D.Sc. degree from the University of Oxford on the occasion of the recent meeting of the British Medical Association.

COLONEL F. HOWARD, Army Medical Service (retired), has been appointed President of a Medical Board to examine candidates for the Royal Military Academy and Royal Military College.

THE Fishmongers' Company have given £500 to King Edward's Hospital Fund, and twelve other smaller amounts to hospitals.

SIR RILEY LORD, when Mayor of Newcastle, succeeded in raising by public subscription £100,000 towards the new Infirmary. Lord Armstrong and Mr. John Hall, shipowner, each gave £100,000 to the same object. Sir Riley has now announced his intention to present a white marble statue of Queen Victoria, to be placed in front of the Newcastle Royal Infirmary.

DR. FREDERICK ROBERTS has been appointed Harveian Orator for 1905, on the nomination of the President of the Royal College of Physicians of London.

### British Medical Association.

SEVENTY-SECOND ANNUAL MEETING,  
OXFORD, 1904.

[THIRD ARTICLE.]

[BY OUR SPECIAL MEDICAL REPORTER.]

#### THE ANNUAL EXHIBITION.

THE annual display of surgical and scientific instruments, sanitary appliances, foods and food products, medical publications and other material pertaining to the realm of the healing art has for long been a particularly valuable feature of the great yearly gathering of British practitioners. There is need, however, that special precautions should be taken to maintain a high standard in the conduct of this periodic exhibition. We are strongly of opinion that the scientific rather than the trade spirit should be dominant in the selection and arrangement of the exhibits. Too often, it has appeared to us, exhibitors have adopted methods more likely to impress a gullible public than influence discriminating practitioners. We consider demonstrations should as far as possible replace mere verbal presentations. All mere vulgar forms of touting should be rigorously discountenanced. It would be well if greater care was taken in the selection of material exhibited; wines, tobacco, and goods not strictly medical or bearing directly on a practitioner's life and work, should be excluded. The catalogue might be made a much more valuable manual for reference if it contained illustrations and descriptions of new appliances. At present the contents are in great measure a mere enumeration of old or would-be favourites. This year's exhibition

reached a high level of excellence, and as far as we were able to see the exhibitors were generally judicious and courteous in urging the claims of their respective preparations. In most instances, the various stalls were arranged to attract professional notice, but one well-known extract of meat company, trading under distinguished directors, adopted a method of attracting public inspection, which, to say the least, was not Oxonian in its scientific modesty.

Mr. Guy Elliston, as manager, has accomplished a particularly difficult task with much tact and judgment. In the future we shall expect even greater advantages to accrue from the new policy of directing and controlling the annual exhibition from headquarters.

#### SURGICAL INSTRUMENTS.

A number of well-known makers were represented. Messrs. Down Bros. showed many new models. Messrs. S. Maw, Son and Sons exhibited a good selection of instruments. John J. Griffin and Sons demonstrated the advantages of the new Harcourt Chloroform Inhaler. John Weiss and Son displayed their products; and Mayer and Meltzer had a good collection of laryngological, aural and other instruments. Messrs. Allen and Hanbury had a very extensive display, and J. Gardner and Son, F. Davidson and Co., Brady and Martin, and the Holborn Surgical Instrument Co. all had interesting exhibits. Arnold and Sons exhibited a number of particularly valuable new inventions.

#### HOSPITAL EQUIPMENT.

The exhibition was particularly rich in material connected with hospital construction and equipment. Messrs. Doulton and Co. showed lavatory and bath fittings; Geo. Gale and Sons showed various forms of their "Lawson Tait" bedsteads and other hospital furniture; the Marshall Sanitary Mattress Co. exhibited mattresses and a convenient "Handy-Cosy" folding bed; the Longford Wire Co. had useful forms of bed fittings; W. H. Bailey and Son showed various novelties and useful types of operation tables; Messrs. Allen and Hanbury had aseptic hospital furniture in phosphor bronze, German silver, and enamelled steel; Messrs. Philip Harris and Co., of Birmingham, also had a good display. Indeed it would seem now that all the best instrument makers and many furnishing firms make the matter of hospital equipment a leading feature; and certainly, judging by the admirable display, at Oxford, the modern has innumerable advantages over the ancient equipment of a few years ago. Frank A. Rogers had a well-arranged exhibit of his sprays and other convenient pharmaceutical preparations. G. H. Neal had an extensive display of clinical thermometers, including the useful "Repello." Aseptic and antiseptic dressings were shown by such firms as Petol, Ltd., Cuxson, Gerrard and Co., Peat Products Co., and the Sanitary Wood-Wool Co. The Berkefeld Filter Co. demonstrated the use of their different forms of filter.

#### ELECTRICAL APPARATUS.

Excellent exhibits of X-ray apparatus, high frequency appliances, and medical electrical equipment were made by Harry W. Cox, the Marconi Wireless Telegraph Co., the Medical Supply Association, and Isenthal and Co. Various models of the Hodgkinson electro-neurotome were demonstrated.

The Dowsing Radiant Heat and Light Co. had an elaborate exhibit of arrangements illustrating their system of treating certain diseases by hot air, the Finsen light, &c.

#### DRUGS AND PHARMACEUTICAL PREPARATIONS.

Many well-known houses made excellent displays of old-established preparations. A few new synthetical bodies were exhibited, but the novelties were rather in the direction of elegance and convenience of form than actual originality in composition.

Burgoyne, Burbidges and Co., showed a number of the useful Heyden pharmaceutical products, including acöine, cresotal, salocrool, and xeroform; C. de Trey and Co. exhibited the new anæsthetic somnoforme; Wyleys, of Coventry, had an attractive show of their

elegant elixirs, syrups, pastilles and other well-known preparations; Hedley and Co. reminded us of the use of ethyl chloride as an anæsthetic; Oppenheimer, Son and Co. showed that "palatinoids" may be employed as a serviceable form of administering many of the new drugs; Parke, Davis and Co. exhibited a collection of their standardised drugs, an excellent collection of sera, and a series of lantern slides illustrating biological and pharmacological processes now employed in the preparation of therapeutic material; the Bayer Co. displayed many synthetic compounds, including the serviceable veronal, somatoc, citarin, aspirin, and heroin; Mr. W. Martindale displayed many of his elegant pharmaceutical preparations, and reminded the profession that a new edition of his invaluable "Extra Pharmacopœia" had just been issued; the Charles H. Phillips Chemical Co. called attention to their Milk of Magnesia and other American preparations; A. and M. Zimmerman had a collection of Schering's and other Continental manufacturers' well-known products; Fairchild Brothers and Foster showed their various digestive products; Jeyes' Sanitary Compounds Co. drew attention to Cyllin, their new name of an old favourite disinfectant (creolin); Angier's Emulsion was also prominently displayed; Duncan, Flockhart and Co. had a good exhibit of anæsthetics, soaps, compressed tablets, and other special preparations; Arthur and Co. showed various cosmetics and other novelties; C. J. Hewlett and Son were well represented by a good display of their well-known mixtures and some new synthetic remedies; Andrus and Andrus exhibited formolyptol and hæmaboloids; H. and T. Kirby and Co. advertised the merits of Purgen; Brady and Martin, of Newcastle-upon-Tyne, also made a good display of many elegant preparations. The Denver Chemical Manufacturing Company has an extensive display of Antiphlogistine a silicate compound which is coming into extensive use as a new form of poultice or compress in swollen joints, for which it forms a firm but flexible support. It has also proved its utility when employed in deep-seated inflammations, and seems likely to attain therapeutic eminence; and the Ferroleum Co. showed their much-lauded emulsion of cod-liver oil, iron and phosphorus.

#### FOODS, DRINKS, AND FOOD PRODUCTS.

As usual, these found place in rich abundance, and oftentimes occupied positions altogether beyond their merits. It is certainly desirable that the exaggerated claims made by the manufacturers of many milk, food and meat preparations should not appear to receive endorsement by the profession. Much discernment and discrimination is necessary in the selection of preparations coming under this head, and we are not convinced that sufficient sifting has been employed in the admission of some to this year's "show."

Liebig's Extract of Meat Co. made a somewhat unusual display of Oxo considering the character of the audience appealed to; the International Plasmon Co. exhibited various preparations of Plasmon; the Maltico Food Co. showed their different specialities; Callard and Co. had a good display of starchless foods; the Shredded Wheat Co. demonstrated the delights of their biscuits; Reynold's Wheatmeal Brown Bread advertised its digestive distinction; the Cheltine specialities were also well to the fore; Cosenza and Co. reminded visitors of the convenience and comfort of Maggi's Consommé; the Galak dry milk claimed to be a veritable food of high excellence; M. Hoff showed his well-known malt extract; Mellin's valuable dietetic preparations were prominent; Cadbury Bros., of Bourneville, showed much tasty chocolate; Irven and Co. exhibited their Klonat brand of dried milk; Armour and Co. had an elaborate display of their animal products, digestive ferments and glandular extracts in tablet and powder form; the Aylesbury Dairy Co. showed samples of their well-known humanised milks; Nestlé reminded visitors of his claims for Milo food and the Viking unsweetened

milk; Brand and Co. exhibited their juices and jellies and other specialities for invalids; Virol and Bovril also had prominent exhibits; Albene, a vegetable fat, was shown by Broomfield and Co.; the Manhu diabetic foods were also exhibited, and Van Abbott and Sons showed their gluten bread and special foods for obesity, diabetes, and various dyspeptic states.

The claims of "waters" seems to be limitless. C. Oppel and Co. displayed Friedrichshall; Ingram and Royle showed many natural mineral waters; Arabella water at least attracted by its name; Idris and Co. made an attractive grouping of their table waters and lime-juice preparations; the Apollinaris Co. demonstrated the purity of the source whence the Apollinaris water is derived, and the value of the now well-known aperient water Apenta; Alexander Riddle and Co., and Feltoe and Smith showed lime and lemon juice preparations; Camwal aerated waters were prominently displayed; Allsopps exhibited their lager beer; Stephen Smith and Co. advertised Hall's Wine; Coleman and Co. showed Wincarnis; and Keinheimer and Co. displayed their Nektar wines.

#### MEDICAL PUBLICATIONS.

We could wish that means could be found whereby all the recently published works could be brought together and conveniently grouped in the form of a temporary library. At the present time the display of medical literature is incomplete and inconvenient, and, we imagine, does little for the publisher, as evidenced by the absence of most of the leading houses, and still less for the serious student. The firms exhibiting this year were John Bale, Sons and Danielsson; Macmillan and Co., H. K. Lewis, Cassell and Co., John Wright and Co., J. B. Lippincott Company, and W. B. Saunders and Co.

#### MISCELLANEOUS.

It is impossible in the limited space at our disposal to indicate all the stands found in the annual exhibition. In addition to those already mentioned reference may, however, be made to various forms of orthopaedic apparatus and appliances for the lame, shown by the O'Connor Extension Company, N. Bletchley, Messrs. Salt and Sons, and F. Gustav Ernst.

W. and A. K. Johnson exhibited a series of diagrams on Hygiene. "Ronuk," Ltd., showed their well-known sanitary polishes for hospital floors. The Trading and Manufacturing Co., of Temple Bar House, demonstrated the advantages of their card index systems. The Cellular Clothing Co. exhibited their Aertex underclothing. The Boroughs of Leamington, Harrogate, and Buxton drew attention to the value of their respective towns as desirable health resorts.

In conclusion, we would again congratulate all concerned in the preparation and conduct of this year's exhibition. We would, however, suggest that in future the usefulness of the catalogue might be increased if a subject index could be added in addition to that of exhibitors and advertisers.

### Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENT.]

#### BELFAST.

**MEDICAL APPOINTMENTS IN BELFAST.**—Dr. W. M. Killen has been appointed attending surgeon to the Benn Ulster Eye, Ear, and Throat Hospital, in place of the late Dr. W. A. McKeown. In consequence of this appointment, Dr. Killen has given up general practice, and has resigned his post of medical attendant to the Royal Irish Constabulary. For this post there are said to be about twenty candidates, who are all hard at work bringing influence to bear on the police authorities. The appointment will be made in the course of the next few days. Another post rendered vacant by Dr. McKeown's death is that of lecturer on ophthalmology and otology at Queen's College. No appointment can be made till the session opens in October,

but it is understood that there will be at least four candidates for the post. The appointment rests in the hands of the College Council.

**HEALTH OF THE CITY OF BELFAST.**—The report of the Medical Officer of Health for 1903 has just appeared, but offers no novel points for comment, being the same hopelessly insufficient document as in past years, chiefly remarkable for its omissions. The number of cases of typhoid and simple continued fever notified fell from 1774 in 1902 to 1,432 in 1903, and the deaths from the same affections from 181 to 144. The rainfall increased from 37 inches to over 44, and probably the thorough flushing of the sewers had not a little to say to the decrease in these diseases. The deaths from phthisis and diseases of the respiratory organs were 2,675, the lowest since 1897. Considering the increase of population this shows considerable improvement, though the deaths from these largely preventable diseases are still fearfully numerous. Three pages of the report are devoted to a detailed history of fifteen cases of small-pox, which occurred in the last three months of 1903, which is rather ancient history now, as we have had an extensive outbreak since then. No maps of the city to show the incidence of various diseases are given, no mention is made of the refuse destructor or its working and we find no reference to the important subject of the inspection of food and seizure of unsound meat, &c. We commend these points to the careful attention of the new chairman of the Public Health Committee, Dr. King-Kerr, and to his medical colleagues on that committee, Dr. A. Browne and Dr. O'Neill.

**PROPOSED SANATORIUM FOR CONSUMPTIVES.**—The question of the proposed sanatorium was under discussion at the monthly meeting of the Belfast Corporation held last week, and some idea of the proposal was sketched by the chairman of the Public Health Committee. The estimated cost of building and furnishing is about £20,000, and it is to be of such a size that 300 to 400 patients can be passed through it each year, at a cost of £6,000, which will be paid by one penny in the pound on the rates. The Board of Guardians will send the more curable cases from the Union Infirmary, and will pay half the cost of maintenance. It is also proposed to take paying patients. Some thirty or forty sites have been offered to the Corporation, and at present these are being examined and plans being perfected, and the whole scheme will shortly be presented to the Corporation for final discussion and decision.

**THE SMALL-POX EPIDEMIC.**—There is a distinct falling off in the number of small-pox cases notified in the last month in Belfast. In the month ending July 16th, there were twelve cases, but none since. There has, however, been an outbreak in Armagh. Two cases were reported on August 3rd, and removed to the fever hospital, where one has since died, and four more cases were admitted the next day. The house in which the first case appeared had been used as a lodging-house for some of the extra police drafted into Armagh during the recent disturbances there, and it is feared that these men may have been exposed to the infection. A number of known "contacts" have been isolated.

### Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—I am a country medical practitioner, and have read Dr. Walsh's able and philosophical articles with the deepest interest. With the greatest industry and economy I can provide for my rent, keep a horse and trap, and pay my way. My wife is a lady by birth, and accepts her share of household drudgery without complaint. We have one child a son, five years of age, whose schooling will soon have to be provided for, but I fear, unless things take a



considerable turn for the better, he will not have that public school training which has been a tradition in my family for generations. The position is this: Here is a struggling professional man just able to make both ends meet by the help of his wife, a refined lady who does the work of a general servant, and yet has to keep up appearances. What would happen if we went on multiplying children, as Dr. Taylor tells us it is our duty to do? Why, my wife would soon be dead, and the children motherless. How could I, deprived of their mother, hope to clothe, feed, and educate those children and send them out into the world with any chance of comfort and success? No. Give me the prudence of prevention rather than the selfish recklessness of over-production. A living neurasthenic is better than a wife in her grave.

I am, Sir, yours truly,  
A COUNTRY PRACTITIONER.

Bucks, August 8th, 1904.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I do not wish to press any advantage, but on referring to the Parliamentary Report, I find that there is a very serious discrepancy between the actual facts and the figures given by Dr. Walsh which cannot be ignored.

From Table III, p. lxxxiii, of the 64th Annual Report of the Registrar-General, I take the following figures:—

		BIRTHS TO 1,000 LIVING.	
Total in England and Wales.		Legitimate.	Illegitimate.
In 1884	.... 33'6	.... 32'0	.... 1'6
In 1901	.... 28'5	.... 27'4	.... 1'1
Loss	.. 5'1	4'6	5

Dr. Walsh states in THE MEDICAL PRESS AND CIRCULAR for July 13th that the total birth-rate in 1884 stood at "31," and builds his main argument on this! I am sorry he has made this mistake, for it has given not only him and myself, but also a kind correspondent who has written to me on the subject, a lot of unnecessary trouble. The illegitimate births have diminished with the general diminishing, but are almost a negligible quantity.

I am, Sir, yours truly,  
JOHN W. TAYLOR.

22 Newhall Street, Birmingham.  
August 3rd, 1904.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am the wife of a curate, who, thanks to the inequalities of incomes in the Established Church, has, at the age of forty, to be thankful for his luck in securing an annual income of £250. On that sum I have to keep house, to feed, clothe, and educate two boys and one girl. That means I must myself do sewing, mending, housework, while the household is pinched and starved merely to ensure the necessities of life. What would have happened had my children been unrestricted—say, eight or ten, as Dr. Taylor says they should be? The prospect is appalling. I should have had to feed them on bread and onions, and turn them out into the world hopelessly handicapped in body and mind—that is to say, had I lived through the toil and worry and the physical drain of multiple child-bearing. Purity and high thinking and social culture do not pay for boots and frocks and food and housing. Why should I bring children into the world on the strength of social and intellectual qualifications that fail to furnish the decencies of life reasonably demanded by my husband's station in society? Does Dr. Taylor think I should have produced those additional children or not?

I am, Sir, yours truly,  
A POOR CURATE'S WIFE.

Manchester, August 6th, 1904.

#### PREVENTION OF PERINEAL RUPTURE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—This well-worn subject, on which you comment

in your last issue, *re* Dr. Laphorn Smith's treatment, should raise a smile. "A little nonsense now and then is relished by the best of men." Dr. Laphorn Smith evidently believes in "a stitch in time," but on the same principle every adult male should have the prostate gland removed so as to avoid the inevitable "hypertrophy," with all its accompanying troubles, later on in life.

The simple plan proposed by me years ago (and which I have never found to fail should I be called to the case *in time*) is simply drawing back the perineum forcibly *during* each pain. The late Dr. Parvin, of Philadelphia, alludes to it in his work, "Science and Art of Obstetrics," page 410, and I make bold to say it will be found the best preventive treatment (no anaesthetics required) of laceration of female perineum.

I am, Sir, yours truly,  
ALEXANDER DUKE.

#### PROPOSED STERILISATION OF CERTAIN DEGENERATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reviewing the above work, your reviewer attempts to give the impression that I advocate suicide as a means of checking degeneracy. I do not. Nature attempts to deal with insanity in this way, but her efforts are not successful. It is in this respect Nature requires our help—sterilisation. If any of your readers will refer to page 10 of the above, they will find the following:—"Keep everything alive. For, if to-morrow every degenerate were killed, but the causes of their being degenerate were unattended to, then as large a number of degenerates would take their place. There is no real cure so long as the causes remain ignored."

I am glad to see your reviewer denounce our present "Christian" custom of allowing "cured" lunatics to marry, or to return to conjugal relations.

I am, Sir, yours truly,  
ROBERT R. RENTOUL.

Liverpool.

#### SOME OF THE NEWER (?) METHODS OF OPENING AND CLOSING THE ABDOMEN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Tweedy states in his letter, in reply to mine on above subject, rather dogmatically: "These so-called 'Bozemann plates' are placed at intervals [*italics mine*] across a wound." Dr. Bozemann states in his letter to me: "There is certainly no object in having a window through which to view the reparative process—the adhesion of the wound would go on just as well *in the dark*." From the tone of his letter I conclude Dr. Tweedy is not quite pleased that the plan to which he called attention and stated "(so far as he knew) was novel," is Nathan Bozemann's pure and simple, and perhaps it would not be too early for him to act on his own advice as regards a post-graduate course!

I am, Sir, yours truly,  
A. D.

London, W.

#### Obituary.

T. GILBART SMITH, M.D.DUB., M.A., F.R.C.P. LOND.

WITH much regret we announce the sudden death of Dr. T. Gilbert Smith, at Twerton, Devon, where he was taking a bicycling tour with his son by way of a summer holiday. Death was due to heart failure, and took place at the comparatively early age of 56. Deceased was for many years on the staff of the London Hospital, as assistant physician, and afterwards as physician. Among other appointments he held that of physician to the Royal Hospital for Diseases of the Chest. He was well known and popular as a teacher of sound as well as of brilliant qualities. Socially, his kind and genial disposition made him the centre of a large circle of friends both inside and outside his own profession. His medical education was

conducted at Dublin University, and at St. Bartholomew's. In 1871, he took the English diploma of M.R.C.S., and in 1885 the Fellowship of the same body. He became bachelor of medicine of Dublin University in 1869, and graduated M.D. T.C. in 1873. Dr. Gilbert Smith was a member of many learned societies, and made numerous contributions to medical literature. His death deprives the distinguished knot of Irishmen in London of a well-known and esteemed figure.

STAFF-SURGEON HENRY SCANLAN, M.B.,  
C.M., Univ. Glasgow.

WE regret to announce the death of Mr. Henry Scanlan, M.B., Staff Surgeon of the Royal Navy, retired, on the 31st ult., at the residence of his brother, Kerswell, Broadclyst, Devon, at the age of fifty-five. After taking the M.B. and C.M. Degree from the University of Glasgow in 1871, he entered the Navy as a Surgeon in March, 1872, and became a Staff Surgeon in March, 1884, serving with the Royal Marine Battalion at Suakim during the operations in the Eastern Soudan in 1884-5, for which he had the medal with clasp and the Khedive's bronze star. He was placed on the retired list in March, 1885.

### Literature.

#### PREVENTION OF DISEASE IN ARMIES. (a)

THE fact that this little volume has brought its author the Parkes Memorial Prize and Bronze Medal should give it a special interest at the outset, as it proves in the most conclusive way the high estimate which has been formed of its contents by those who are, presumably, among those who are best qualified to form an opinion on the subject. On this fact by itself we cordially congratulate the author and his publishers. Major Caldwell tells us in his preface that: "This little book has been written in the hope that what is, in the main, a record of sanitary experience in the field may possibly prove of some interest to those whose attention is particularly drawn to the physical well-being of the soldier on service." But the great merit of the volume, to over-read reviewers and journalists, is indicated in the next sentence: "I must apologise for the constant introduction of the personal element on the ground that I have endeavoured to formulate my own conclusions from my own experience, and to avoid the repetition of well-known matter." The way in which Major Caldwell has followed out the lines of the chart thus indicated would, in our opinion, have earned for him the merit of a foremost place in any series of contributors to the literature of scientific medicine. And, in the present instance, a glance at the title-page will show what excellent opportunities he has had for forming opinions based upon ripe experience, gathered in widely-separated regions of the earth's surface. The award of the Parkes Memorial Prize shows what the judges thought of the value of his opinions, and we heartily endorse their view of the sterling merit of his volume.

The contents are arranged in six chapters:—I.—Introduction. II.—Diseases of Soldiers in the Field. III.—Administrative Matters Affecting the Health of Troops in the Field. IV.—Sanitary Measures in the Field. V.—The Sanitary Organisation of a Field Force. VI.—General Conclusions and Recapitulation. The contents are of special interest at the present date, giving, as they do, so excellent a summary of sanitary and insanitary methods and experiences connected with the recent war in South Africa—accentuated, of course, by the increasing war and rumours of wars in the Far East at the present date. Strange recollections of infection are necessarily interspersed in the wide experience of Major Caldwell. The occurrence of

(a) "The Prevention of Disease in Armies in the Field." By Robert Caldwell, F.R.C.S., D.P.H., Major R.A.M.C. Member of the late War Office Committee on Field Sanitation in connection with the South African Campaign; late Member Sanitary Committee, Island of St. Helena; Senior Medical Officer, Zululand; Medical Officer in Charge of Isolation Hospital and District Laboratory, First Army Corps. London: Baillière, Tindall and Cox. 1904. Crown 8vo, pp. viii and 182, and 28 illustrations. Price 5s. net.

a case of ague in St. Helena is an instance. Endemic malaria is unknown in that island; and the patient had never in his life been exposed to possible mosquito contact, except on the occasion of his return from a visit to England. He then passed so "close to the land while near Cape Verde—so near that the passengers could plainly distinguish trees and human habitations." Shortly after landing in St. Helena he was seized with a severe attack of ague. . . . The only possible explanation, according to the theory of malarial contagion now established by scientific research, is that some of the mosquitoes were wafted on board from the tainted African coast. Of the excellent illustrations which accompany Major Caldwell's text we must specially point out—"Fig. 1. Scene near Summit of Drakensberg. The surroundings were typically healthy, and the water was of excellent quality, and drawn from rock springs. In spite of these advantages, enteric fever occurred (in a mild form) among the troops in the district." The explanation—the only possible one—is furnished on the next page: "The camp had been occupied for some months before the disease broke out, and although every possible sanitary precaution was most faithfully carried out, the avoidance of soil pollution was a matter of impossibility." We will make no further extracts, and close this notice of an admirable thesis by recommending its pages to the attention of all our readers.

#### MIDWIFERY FOR MIDWIVES. (a)

THE aspirant midwife is receiving more than her share of attention at the present time, and numerous indeed are the works submitted for her approval by authors, lay and medical. Dr. A. B. Calder's "Questions and Answers on Midwifery for Midwives" is a highly condensed synopsis of the information required by the candidate for the L.O.S. certificate. First we have brief anatomical details of the female reproductive apparatus, followed by a fairly full description of normal labour. In this connection we should like to know what practical bearing the following remark can have: "If ante-partum eliminations have been thoroughly aseptic, no douche will be required." Who can answer that question? And, failing an answer, is the douche to be given or not? Then we have definitions of the normal and abnormal child and the normal and abnormal labour, the author having overcome the difficulty experienced by the originators of the Midwives Bill in distinguishing between the two. Finally, model answers to questions, together with a selection of questions actually put. This little volume is a perfect epitome of what to do and what not to do in the lying-in room, and a candidate who had assimilated its contents even approximately would not fail to carry all before her. It is, in fact, a Liebig's Extract of obstetrical principles for midwives' and nurses' use.

#### SIR JAMES SAWYER ON INSOMNIA. (b)

SIR JAMES SAWYER has recently published an interesting collection of clinical lectures under the title of "Contributions to Practical Medicine," and the work before us comprises the first two chapters of those essays. Insomnia is a subject which always attracts a good deal of attention, although it cannot be regarded as a disease, and is simply a symptom of some underlying functional or organic disturbance. The author arranges the different clinical varieties into groups, which he calls respectively "psychic," "toxic," and "senile." A most interesting and graphic sketch is given of intrinsic insomnia as met with in general practice, the illustration employed being that of a young professional man without adequate means waiting for the advent of clients. Attention is directed to the causal association of a nervous temperament with this

(a) "Questions and Answers on Midwifery for Midwives." By A. B. Calder, M.B., M.R.C.S. Pp. 148. Price 1s. 6d. net. London: Baillière, Tindall and Cox.

(b) "Insomnia: its Causes and Cure." By Sir James Sawyer, M.D., F.R.C.S., Senior Consulting Physician to the Queen's Hospital, Birmingham.

form of insomnia and stress is laid on the importance of recognising and studying that individual peculiarity of physical organism by which the manner of acting, feeling, and thinking of every person is permanently affected. Under the head of the senile variety, it is pointed out that the broken and short sleep of many old persons is the result mainly of degeneration of the smaller cerebral arteries. This is the explanation of the exaggerated appreciation of the merits and value of early rising so often observed as age advances. In the second chapter, which is devoted to the "Cure of Insomnia," much valuable advice is given respecting the routine employment of hypnotics. "Prescribe hypnotics only in exceptional cases." "Never allow a patient to dose himself with hypnotics." This is good advice, and there are many equally useful hints in this admirable work. We find a reference to tar-water and to the writings of the Rt. Rev. Dr. George Berkeley, Lord Bishop of Cloyne. What we miss, however, is some reference to the frequent toxic action of sulphonal on the kidneys when taken in even comparatively small doses. There have been so many deaths from this cause that it is difficult to ignore the danger. Sir James Sawyer has written a most interesting, and, if we may venture to say so, amusing book, containing much good, sound, practical advice, which will be found useful to everyone in practice.

#### THE THERAPEUTICS OF MINERAL SPRINGS AND CLIMATES. (2)

DR. BURNEY YEO has produced an admirable work on mineral springs and climates founded on many years' practical experience revised and brought thoroughly up to date as the result of a long self-imposed winter holiday. It is not every physician in active practice who can afford the necessary time to visit the various places he describes, and too often the knowledge is obtained second hand, and is little more than an abstract of the information given in guide-books and pamphlets published locally. There is a distinct demand for a good and thoroughly trustworthy work of this description, for it appeals not only to medical men, but to the vast army of valetudinarians who spend the greater part of the year travelling from one health resort to another. "Where to go" is a common topic of conversation, and the practitioner who is not thoroughly acquainted with the subject finds himself at a disadvantage. Macpherson's "Baths and Wells of Europe" is an excellent work, but it is out of date, and requires revision, and the same may be said of the "Mineral Waters and Health Resorts of Europe," by Sir Hermann Weber and Dr. F. Parkes Weber. The "Climates and Baths of Great Britain," published by a Committee of the Royal Medical and Chirurgical Society of London, although good in intention, failed to attract the notice which from the reputation of the contributors it deserved. Dr. Yeo's book, which is in the main arranged alphabetically, deals not only with climates and climatic resorts, but with mineral springs. His introductory chapter on the nature, composition, and classification of waters is practical and to the point. A large proportion of our medicinal waters come from Germany and Austria, and the number in Great Britain is, unfortunately, comparatively small. The subject of table waters has of late occupied much attention, and the author treats fully of Apollinaris, St. Galmier, and the seltzers. He, however, as far as we have been able to discover, omits all mention of Source Perrier from Vergèze, in the department of Gard, France, a water now extensively used on the Continent, and universally drunk on the Riviera. Source Perrier is a first-rate table water; it is absolutely pure and free from contamination, and is strongly effervescing with its own natural carbonic acid gas. This is but a small omission, and will doubtless be remedied in future editions. Among the bitter or purgative waters Apenta comes in for a large share of attention, but, curiously enough, Hunyadi Janos is dismissed in four

lines of small type, and *Æsculap* is equally summarily dealt with. This is to be regretted, for it gives one the idea of want of proportion. We have looked for some information on *Arabella Water* from Kelenföld, in Hungary, but do not find it mentioned. A good account is given of the mode of treatment adopted at Harrogate, and justice is done to the improvements recently effected at this popular English health resort. Going further afield, we find an excellent description of *Hammam R'Irha*, in Algiers, but surely the place from which it is most conveniently reached is *Bou Medfa*, and not "Bon Medfa."

#### SAUNDERS' YEAR-BOOK. (4)

THERE is no other book in the English tongue which exactly corresponds in scope and aim with "Saunders' Year-Book of Medicine and Surgery," which has recently reached us. It is described on the title-page as a "yearly digest of scientific opinion," and it is only just to say that it is something more than a mere abstract of articles that have appeared during the year. The general editor, Dr. George Gould, has been aided by a large group of collaborators, each of whom is to be regarded as of authority in the particular subject which has been entrusted to him. We may specially mention as men whose names are well known and respected on this side of the Atlantic, Dr. Alfred Stenge, of Philadelphia, who edits the section of General Medicine, Dr. David Riesman, who writes on Pathology, and Dr. G. U. Stewart on Physiology. As is necessary in a work of this kind, there is but little room for the expression of individual opinion, since it is necessary to find place for a mention at least of anything new that has appeared during the year. At the same time, a considerable amount of selective care is required from the editors, not merely in judging what views are worthy of notice, but in deciding the relative space to be allowed to each. In addition, each chapter opens with a short summary of the most noteworthy advances made during the year. This feature is of immense convenience to the casual reader, who, not being bent on following any particular lines of study, wishes to grasp in short any new and interesting facts which have arisen. Should he wish to pursue his reading further ample help is given by reference to the original articles. As is perhaps natural, there is somewhat an unnecessary preponderance of reference to American rather than to English and foreign journals, though this is less marked in the sections devoted to pure science, such as those of anatomy and physiology, than in those devoted to clinical and practical work. Coming to the discussion of particular subjects, and choosing a few sections almost at random, we find an excellent though concise description of paratyphoid fever, our principal knowledge of which comes from the States. It is interesting to note that the editors maintain a sceptical attitude with regard to Councilman's discovery of a small-pox parasite, thereby placing themselves rather in line with European opinion than with what appears to be received in their own country. They are also unconvinced as to the necessity of believing in the parasitic origin of carcinoma. Having noted the general lines of investigation in pathology, the editors draw attention in particular fields to three recent developments which they regard as of prime interest. They are the results attained by Poyntan and others in the investigation of the bacteriology of acute rheumatism, the inoculation by Tomaszewski of a monkey with Ducrey's soft chancre bacillus and the inoculation of a monkey with syphilis by Roux. It is, of course, impossible for us to do more than suggest in the vaguest way the scope and style of the book, which in truth covers every subject of medical interest. It is alike invaluable to the busy practitioner, who must acquire his knowledge in concentrated doses, and to the student who will regard it as a critical guide to the original documents. It is furnished with a full and excellent index.

(1) "The Therapeutics of Mineral Springs and Climates." By J. Burney Yeo, M.D., F.R.C.S., Consulting Physician to King's College Hospital. London: Cassell and Co., Limited.

(2) "Saunders' Year-Book of Medicine and Surgery." Under the general editorial charge of George M. Gould, M.D. London and Philadelphia: W. B. Saunders and Co. 1904. 3 vols. 16s. net.

**TEXT-BOOK OF LEGAL MEDICINE. (a)**

TWELVE months ago the first volume of this excellent text-book was reviewed in our columns, and we are pleased to be able to say that this, the second volume, maintains the high standard attained by its predecessor. The book consists of a series of well-written monographs by the best-known American specialists, which have been inserted without change by the editors. For convenience of reference the volume is divided into two parts, of which the section on toxicology forms one. The reader must, in consulting the volume, keep well in mind that throughout the work American law and nomenclature is referred to and quoted, and not British law; and, farther, that the American law is modified in some of the commonwealths. The nomenclature of drugs and chemicals used is that adopted by the United States "Pharmacopœia." The illustrations are numerous, well selected, original, and helpful. Many of them are coloured, and that which shows the spectra of human blood is a model of accuracy and beauty. There are many black and white illustrations and diagrams; but, after all, the value of the book lies in the letterpress. The articles on non-alkaloidal poisons, gaseous poisons, food poisoning, and ptomaines bring before the reader the most recent discoveries in analytical chemistry, bacteriology, and pathological anatomy. The toxicologist will find in them a good and full summary of our most recent knowledge on the subject. Few pages are taken up with the subject of malpractice, which contains many valuable hints for the general practitioner; and we cannot but wish that some of the decisions quoted, especially of English Judges, were more generally known and more frequently acted on, as they would tend to restrain quackery, the tolerance of which is one of the greatest of modern evils.

**Medical News.****Royal College of Physicians, London.**

At a meeting of the College held on July 28th, the following appointments were made:—Censors: Dr. Thomas Henry Green, Dr. William Henry Allchin, Dr. Norman Moore, and Dr. Frederick Taylor. Treasurer: Sir Dyce Duckworth. Emeritus Registrar: Sir Henry Alfred Pitman. Registrar: Dr. Edward Liveing. Harveian Librarian: Dr. Joseph Frank Payne. Assistant Registrar: Dr. Oswald Auchinleck Browne. Elected Members of the Library Committee: Dr. Philip Frank, Dr. Norman Moore, Dr. William Henry Allchin, and Dr. Archibald Edward Garrod. Curators of the Museum: Dr. William Howship Dickinson, Dr. Henry Charlton Bastian, Dr. William Cayley, and Dr. John Abercrombie. Finance Committee: Dr. George Fielding Blandford, Dr. James Frederick Goodhart, and Sir Isambard Owen. Examiners: Chemistry and Chemical Physics: Mr. Harold B. Dixon, F.R.S., Mr. John Millar Thomson, F.R.S., Mr. Frederick Daniel Chattaway, Ph.D., D.Sc., Mr. Alexander Mitchell Kellas, F.C.S., and Mr. John Addyman Gardner, F.C.S., F.I.C. Materia Medica and Pharmacy: Dr. Frederick Willcocks, Dr. Walter Essex Wynter, Dr. Henry Albert Caley, Dr. Francis Whittaker Tunnicliffe, and Dr. James Purves Stewart. Physiology: Dr. Ernest Henry Starling, Dr. Bertram Louis Abrahams, and Dr. Leonard Erskine Hill. Anatomy: Dr. Bertram C. A. Windle, F.R.S., and Dr. Robert Howden. Medical Anatomy and Principles and Practice of Medicine: Dr. Samuel Hatch West, Dr. Theodore Dyke Acland, Dr. George Newton Pitt, Dr. Sidney Philip Phillips, Dr. William Pasteur, Dr. William Collier, Dr. Norman Dalton, Dr. Frederick John Smith, Dr. Francis George Penrose, and Dr. John Rose Bradford, F.R.S. Midwifery and Diseases Peculiar to Women: Dr. Alfred Lewis Galabin, Dr. Francis Henry Champneys, Dr. George Ernest Herman, Dr. William Rivers Pollock.

(a) "A Text Book of Legal Medicine and Toxicology." Edited by Frederick Peterson, M.D., President of the New York State Commission in Lunacy; Clinical Professor of Psychiatry, Columbia University, New York; and Walter S. Haines, M.D., Professor of Chemistry, Pharmacy, and Toxicology to the Rush Medical College, Chicago; Professorial Lecturer on Toxicology in the University of Chicago. In 2 vols. Vol. II. Philadelphia, New York, London: W. B. Saunders and Co. 1904.

and Dr. Edward Malins. Public Health: Part I.—Dr. Arthur Pearson Luff. Part II.—Dr. William Heaton Hamer.

**Royal Veterinary College, Edinburgh.**

As it has now been definitely settled to transfer "the new veterinary College" from Edinburgh to Liverpool, in October, the original "Royal Veterinary College," founded by the late Professor Dick eighty years ago, will henceforth be the only one for veterinary students in the Northern capital, the rivalry of the "new" college will cease, and we hope it will again attain the former success which marked its progress in years gone by, the opinion being generally expressed that the profession is too small to support two institutions of the kind in Scotland. The Royal or Dick's, as it is more familiarly called, covers an extensive site in Edinburgh, and is provided with more complete laboratories, dissecting rooms, class rooms, museum, and anatomical departments than any similar Institution in the United Kingdom, with a professional staff of both veterinary and medical practitioners of considerable eminence.

**Senate of the Royal University of Ireland.**

MR. CHARLES CRAIG, last week, in the Commons, asked the Chief Secretary to the Lord Lieutenant of Ireland whether his attention had been called to a meeting of the Royal University Graduates' Association held in Belfast on July 18th, at which Dr. Leslie was unanimously selected as the candidate whose claims should be brought before the Government for appointment to the vacancy on the Senate of the Royal University caused by the death of Dr. William McKeown; and whether, having regard to the fact that the Royal University Graduates' Association represented the opinions of a large proportion of the graduates of the Royal University and of the public in the North of Ireland and that the late Dr. McKeown was the representative of this opinion in the Senate, the Government would appoint Dr. Leslie to the vacant seat to preserve the continuity of representation of this opinion. Mr. Wyndham said:—"Representations have been made in favour of the appointment of Dr. Leslie to fill the vacancy on the Senate caused by the death of Dr. McKeown. These will be considered by the Government."

**Management of Horton Lunatic Asylum.**

MR. WHITMORE, in the Commons last week, asked the President of the Local Government Board whether his attention had been called to the case of R. S. Clarke and others, tried at last assizes at Guildford, on July 19th, and to the finding of the jury that they were of opinion that the Horton Lunatic Asylum had been grossly mismanaged and that the conduct of the persons responsible for the administration of the Asylum should be at once seriously inquired into; and whether he proposed to take any action in the matter. Mr. Akers-Douglas said:—"My right honourable friend has asked me to answer this question. I am informed by the Commissioners in Lunacy that the matter is receiving careful consideration and that they are awaiting the report of a sub-committee appointed by the Asylums Committee of the London County Council to inquire into the question.

**Death from Anthrax.**

MR. MACDONA asked the Secretary of State for the Home Department whether he was aware that at an inquest recently held in Liverpool upon a man who had died from anthrax it came out in the evidence that the deceased was shaved by a barber in Liverpool shortly before his death, who, at deceased's request, cut open the swelling upon the deceased's face, thus causing a serious risk of anthrax being further spread, and, if so, whether he would take steps to prevent a recurrence of such action. Mr. Akers-Douglas replied:—"I am informed that the facts are as stated in the first part of the question. The matter is entirely outside the scope of the Factory Act and I have no power to take any action, but I may say that I am advised that the risk of anthrax being spread in this way would be small."

**An Irish Question.**

MR. HAYDEN asked the Chief Secretary to the Lord

Lieutenant of Ireland whether he could state the total number of assistant medical officers of lunatic asylums in Ireland and of these how many were married. Mr. Wyndham said:—"The total number of assistant medical officers in district asylums is thirty-five. No married man can be appointed to this position. I have no information as to marriages, if any, contracted subsequently to appointment."

#### University of Durham.

A MEETING of members of the University of Durham was held on July 25th, in the Owens College Union Rooms, for the purpose of forming a "Manchester Association of Members of the University of Durham." Further information may be had from Mr. Bennett, Secretary, 309, Waterloo Road, Manchester.

#### Chicken-Pox.

THE London County Council has decided that chicken-pox shall be a notifiable disease for a further period of three months.

#### Royal College of Physicians, London.

THE following candidates, having passed the requisite examinations, were admitted Members of the College on July 28th:—John Frederick Gordon Dill, M.A., M.D.Cantab.; Edward Henry Douty, M.A., M.D.Cantab., L.R.C.P.Lond.; Wilfred Stephen Fox, M.A.Cantab., L.R.C.P.Lond.; Ernest Edward Glynn, M.A., M.B.Cantab., L.R.C.P.Lond.; Henry Lawrence McKisack, M.D.R.U.I.; Geoffrey Richard Slade, M.A., M.D.Cantab., L.R.C.P.Lond.; and Thomas Grainger Stewart, M.B.Edin.

At the same meeting the L.R.C.P.Lond. was granted to 115 gentlemen who had passed the required examination.

Diplomas in Public Health were also granted to the following:—Charles Thomas Blackwell (Major R.A.M.C.), M.D.Durh., L.R.C.P. & S.Edin.; Dunstan Brewer, L.R.C.P.Lond., M.R.C.S.Eng.; John Catto, M.B., B.S.Aberd.; Basanta Kumar Chatterjee, L.R.C.P. & S.Edin., L.F.P.S.Glasg.; Stanley Cornell Clapham, L.R.C.P.Lond., M.R.C.S.Eng., M.B., B.S.Durh.; John Matthewson Clements, M.B., B.Ch.R.U.I.; Walter Ernest Llewellyn Davies, L.R.C.P.Lond., M.R.C.S.Eng.; Thomas Stokoe Elliot, L.S.A.; Norman Faichnie (Major R.A.M.C.), M.B., B.S.Durh.; Henry William Grattan (Captain R.A.M.C.), L.R.C.P.Lond., M.R.C.S.Eng.; John William Gromitt, L.R.C.P.Lond., M.R.C.S.Eng.; Hugh Llewellyn Jenkins, M.B., Ch.B. Vict.; John Isaac Pratt, L.R.C.P.Lond., M.R.C.S.Eng., M.B.Toronto; Morgan James Rees, L.R.C.P.Lond., M.R.C.S.Eng., M.B.Lond.; Frank Ernest Rock, L.R.C.P.Lond., M.R.C.S.Eng., M.D.Lond.; Godfrey William Simpson, L.R.C.P.Lond., M.R.C.S.Eng.; Charles Augustus Spooner, L.R.C.P. & S.Edin., L.F.P.S. Glasg.; John Charles Baron Statham (Captain R.A.M.C.), L.R.C.P.Lond., M.R.C.S.Eng.; John Robert Steinhäuser, L.R.C.P.Lond., M.R.C.S.Eng., M.B. & B.S.Lond.; Robert Lewis Thornley, L.R.C.P.Lond., M.R.C.S.Eng., M.D.Lond.; Philip Vickers, M.B., Ch.B.Edin.; and William McConnel Wanklyn, L.R.C.P.Lond., M.R.C.S.Eng.

#### Royal College of Surgeons of Edinburgh.

At a meeting of the College held on July 28th, the following gentlemen, having passed the necessary examinations, were admitted Fellows of the College:—David Macrae Aitken, M.B., Ch.B., Robert Gordon Bell, M.D., Chiranjiva Bharadwaja, L.R.C.S.E., William Thomas Chenhall, M.D., Frederick Gardiner, M.D., Alfred Griffiths, M.B., C.M., Arthur Gwyther, M.B., C.M., Captain I.M.S., Thomas Dufour Halaban, M.B., Claude Somerville Hawkes, M.R.C.S.Eng., Edmund Moritz Illington, M.R.C.S.Eng., Captain I.M.S., James Frederick Merrillees, M.B., Ch.B., Thomas Mill, M.B., Ch.B., Philip Henry Myles, M.B., L.R.C.S.E., Lionel Charles Peel Ritchie, M.B., Ch.B., Oscar Bagster Trumper, M.B., Ch.B., and Henry Woolmington Webber, M.D., M.R.C.S.Eng. The medal and set of books forming the "Bathgate Memorial Prize," presented to the College by Colonel William Lorimer Bathgate in memory of his late father, William McPhune Bathgate, Fellow of the College, was awarded to Mr. Robert Macnaught Glover, Carlton House, Dumfries.

#### University of Liverpool.

THE following candidates (arranged alphabetically) have passed the second M.B. and Ch.B. examination:—

A. *Anatomy and Physiology*.—J. W. Cropper, and G. W. Williams.

B. *Materia Medica and Pharmacy*.—T. T. Apsimon, E. R. Armstrong, A. C. Edwards, S. J. C. Holden, A. Jones, T. Martlew, W. R. Pierce, J. H. Rawlinson, A. M. M. Roberts, R. S. Taylor, and S. V. Tinsley.

The following have passed the final M.B. and Ch.B. examination:—

Part I.—J. F. Edmiston, B. T. J. Glover, T. E. Jones, J. F. McCann, J. McClellan, S. W. McLellan, R. H. Mole, L. D. Napier, T. W. Parry, C. H. Smith, F. H. Storey, C. Yorke, and W. Yorke.

Part II.—The following candidates have passed the final examination for the Degrees of Bachelor of Medicine and Bachelor of Surgery with Second Class Honours:—P. Hick, and T. F. Walker.

The following candidates have passed the final examination for the Degrees of Bachelor of Medicine and Bachelor of Surgery:—A. E. Grisewood, W. L. Hawksley, G. J. Keane, W. A. Kidd, and G. C. Scott.

The following candidate has passed the examination for the Diploma in Public Health:—D. T. Barry, M.D.

The following candidates have passed the examination for the Diploma in Tropical Medicine:—T. M. Clayton, M.B., B.S., Saikunzafor Khan, M.B., B.S. Hehir, Major I.M.S., M.D., F.R.C.S., A. R. Maclurkin, M.B., Ch.B., J. E. Nicholson, Lieut.-Colonel R.A.M.C., M.R.C.S., L.R.C.P., N. Phillipson, L.R.C.P., and S. Edin.

#### Army Medical Service.

THE following is an official list of candidates who were successful at the recent examination in London for Commissions in the R.A.M.C. (arranged in the order of merit), for which 40 candidates entered.

William Byam, M.R.C.S.Eng., L.R.C.P.Lond.  
Charles Ryley, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.  
Harry Theodore Wilson, M.R.C.S.Eng., L.R.C.P.Lond.

Lionel Victor Thurston, M.R.C.S.Eng., L.R.C.P.Lond.

Walter Hyde Hills, M.B., B.C., and B.A.Cantab.  
Patrick Dwyer, M.B., B.Ch.R.U.Irel.  
Phillip Claude Davy, M.R.C.S.Eng., L.R.C.P., M.B.Lond.

John Forbes Cock Mackenzie, M.B., B.S.Melbourne.  
Arthur William Gater, M.R.C.S.Eng., L.R.C.P.Lond.  
George Alfred Duncan Harvey, L.R.C.P. & S.Irel.  
Harold Charles Winckworth, M.R.C.S.Eng., L.R.C.P.Lond.

James Campbell, M.B., B.Ch.R.U.Irel.  
Richard Collis Hallows, M.B., B.Ch., B.A.O., B.A.Dub.

Harry William Russell, M.B., B.Ch.Vict.  
George Richard Painton, M.R.C.S.Eng., L.R.C.P.Lond.

Meurice Sinclair, M.B., B.Ch.Ed.  
Evelyn John H. Luxmore, M.R.C.S.Eng., L.R.C.P.Lond.

Kenneth Alan C. Doig, M.R.C.S.Eng., L.R.C.P.Lond.  
Herbert Owen M. Beadnell, M.R.C.S.Eng., L.R.C.P.Lond.

Herbert St. Maur Carter, M.D., M.B., B.Ch., B.A.Dub.  
Robert Harry L. Cardner, M.R.C.S.Eng., L.R.C.P.Lond.

John Patrick Lynch, L.R.C.P. & S.Irel.  
Alastair Norman Fraser, M.B., B.Ch.Ed.  
Nelson Low, M.R.C.S.Eng., L.R.C.P.Lond.  
Percy Arnold Jones, M.R.C.S.Eng., L.R.C.P., B.A.Cantab.

Cecil Roy Millar, L.R.C.P. & S.Irel.  
Augustine Thomas Frost, M.D., B.Ch.R.U.I.  
George Herbert Richard, M.R.C.S.Eng., L.R.C.P.Lond.

Harry Christopher Sidgwick, M.R.C.S.Eng., M.B. & B.A.Cantab.

John St. Aubyn Maughan, L.R.C.P. & S.Edin., L.F.P. & S.Glasg.

## 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.

MR. MILNE is thanked for his communication.

**A PROVINCIAL PRACTITIONER.**—The title of the journal referred to was changed in the hope of a wider field; it did not however succeed, and was finally discontinued some two or three years since.

**EDINBURGH.**—The book is an excellent one, you cannot do better than study its contents before going up for your final.

### THE LANGUAGE OF MEDICINE.

[The doctor certified that he was suffering from epistaxis.—Police Report.]

Of doctor's language I must hold  
That there is this to claim for it,  
That when I have a beastly cold,  
I like some other name for it.  
And oh! how soothing doctors are  
To call it bronchial catarrh.

With new and active sympathies  
Friends look—or so we dream—at us,  
To learn we have a skin disease,  
We fear, is exanthematous.  
But how their pity'd fade to find  
'Twas measles—of the German kind.

We must feel pride on learning how  
Distressing our ingultus is:  
We like the new complaint, but vow  
The one way to insult us is  
To hint it is that vulgar thing  
Far better known as hiccuping.

And Polysyllables of size.  
In 'itis' if they terminate,  
Impress with sorrow and surprise  
seven hearers, I affirm, in eight.  
So delicately each reveals  
The pains that Little Mary feels.  
When to such terms the doctor lends  
His countenance and signet, he  
Wakes envy in the patient's friends  
And gives disease such dignity,  
That mortals yearn and sigh for still  
The happiness of being ill.

M.—*Daily Chronicle*.

DR. J. E. R.—The appeal by Mr. Labouchere in the case of "Dakyl v. Labouchere" for a new trial on the score of misdirection has succeeded, but this will not come on before the Autumn sittings of the Court. The costs in the appeal case will carry those of the first trial whatever the ultimate verdict.

## Vacancies.

- Devon County Asylum.—Assistant Medical Officer. Salary £125 per annum, with board and lodgings. Applications to the Medical Superintendent, Asylum, Exminster.
- Dumfries and Galloway Royal Infirmary. Assistant Medical Officer. Salary £80 per annum, with board and washing. Applications to Mr. Symons, Secretary and Treasurer, 14, Irish Street, Dumfries.
- Hulme Dispensary, Dale Street, Stretford Road, Manchester.—House Surgeon. Salary £150 per annum, with apartments, attendance, coal, and gas. Applications, to the Honorary Secretary Medical Committee.
- Hereford County and City Asylum.—Senior Assistant Medical Officer. Salary £150 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent.
- Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Northwood.—Resident Medical Officer. Salary £80 per annum, with board and residence. Applications, to William J. Morton, Secretary, 7 Fitzroy Square, W.
- Royal Lancaster Infirmary.—House Surgeon. Salary £100 per annum, with residence, board, attendance, and washing. Applications to the Secretary.
- County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer. Salary £150 per annum, together with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.
- South Shields Union.—Assistant (Resident) Medical Officer. Salary £200 per annum. Applications to J. W. Coulson, Clerk to the Guardians, Union Offices, South Shields.

## Appointments.

- BLACKALL, J. J., M.D., at S.Q.U.I., Certifying Surgeon under the Factory Act for the Killdybert District of the county of Clare.
- BURTON, H., L.R.C.P.I., L.R.C.S.Eng., Certifying Surgeon under the Factory Act for the Marple District of the county of Chester.
- DWAN, J. H., L.R.C.P.I., L.R.C.S.I., Certifying Surgeon under the Factory Act for the Rathgormuck District of the county of Waterford.
- EAMES, E. S. B., M.B.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory Act for the Uffculme District of the county of Devon.

- FORBES, JAMES GRAHAM, M.D., D.P.H.Cantab., M.R.O.P.Lond., Assistant Physician to the Metropolitan Hospital, Kingsland Road.
- GRAHAM, E. B., L.R.C.P., F.R.C.S.Edin., Certifying Surgeon under the Factory Act for the Leven District of the county of Fife.
- HANDLEY, W. SAMPOX, M.S.Lond., F.R.C.S., a Hunterian Professor of Pathology in the Royal College of Surgeons of England.
- LACKIE, J. LAMOND, M.D., F.R.C.P.E., Assistant Physician to the Royal Maternity and Simpson Memorial Hospital, Edinburgh, and Examiner in Obstetrics, University of St. Andrews.
- LEICESTER, M. E. M.D., Brux., L.R.C.P., L.R.C.S.Edin., L.S.A., Medical Officer for the No. 3 District of the Liskeard (Cornwall) Union.
- MACDONALD, D. J., M.B., M.S.Aberd., Certifying Surgeon under the Factory Act for the Stornoway District of the county of Ross and Cromarty.
- MCCENRY, D., L.R.C.S., L.R.C.P.Edin., Certifying Surgeon under the Factory Act for the Ballmacarbery District of the county of Waterford.
- MAGRATH, H. G., L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasg., certifying Surgeon under the Factory Act for the Cranborne District of the county of Dorset.
- MC SWINEY, M., M.B., M.A.O.R.U.I., Certifying Surgeon under the Factory Act for the Johnstown District of the county of Cork.
- QUIKKE, J., L.R.C.P.I., L.R.C.S.I., Certifying Surgeon under the Factory Act for the Piltown District of the county of Kilkenny.
- SPON, HARRY JAMES, M.B.C.S.Eng., L.R.C.P., D.P.H.Camb., surgeon to the Surrey Dispensary.

## Births.

- DUKA.—On August 3rd, at Lismore, New South Wales, the wife of Albert Theophilus Duka, M.A.Cantab., M.B.C.S., L.R.C.P., D.S.O., of a son. (By Telegram.)
- MELDON.—On August 4th, at 123 Morehampton Road, the wife of Dr. Pugin Meldon, of a daughter.
- ROGERS.—On August 1st, at Charlton, Wimborne Road, Bourne-mouth, the wife of Surgeon Major F. A. Rogers, Indian Medical Service, of a daughter.

## Marriages.

- BOYCOTT—AGG.—On August 4th, at St. Matthew's Church, Westminster, Authur Edwin Boycott, M.D.Oxon, second surviving son of William Boycott, Hereford, to Constance Louisa, second daughter of the late Colonel W. Agg, and of Mrs. Agg of Cheltenham.
- COOPER—BUTLER.—On July 27th, at Turnham Green, William Bertram Cooper, M.R.C.S.Eng., L.R.C.P.Lond., of Chiswick, youngest son of the late W. G. Cooper, of Keaxington, to Esther Maud (Stella), eldest daughter of the late J. M. Butler and of Mrs. Butler of Chiswick.

## OPERATIONS.—METROPOLITAN HOSPITALS.

- WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopaedic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street (9.30 a.m.), Gt. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynaecological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopaedic (2.30 p.m.), Soho Square (2 p.m.).
- SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (10 p.m.) Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).
- MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynaecological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopaedic (2 p.m.), City Orthopaedic (4 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).
- TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).



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## Original Communications.

### THE STUDY OF BIONOMICS IN RELATION TO THE DIMINISHING BIRTH-RATE.

By W. R. MACDERMOTT, M.B.

I HAD written a criticism of Dr. J. W. Taylor's article on the declining birth-rate intended for this journal and laid it by, only to find it anticipated in material respects by Dr. David Walsh. Not, however, completely or to the exclusion of what I thought the most essential point. That point I find well stated in a leading article in THE MEDICAL PRESS AND CIRCULAR of July 27th, 1904, to the effect "that the whole matter appears to be on the borderland where laws are beginning to loom from the dense mists of half knowledge and speculation." This statement recalled to my mind the article I had written, as it put tersely the position I had taken in it. But the question further occurred to me why this should be the case, whether from the inherent difficulty of the subject itself or from a vicious method of studying it, a method vitiated by non-scientific deference to traditional preconceptions.

In Ireland the birth-rate has fallen more than, I venture to say, in any country in Europe. Again, it has fallen most in rural districts, least in the cities. Thus, in the report of the Registrar-General for the quarter ending March 31st, 1904, the birth-rate for Dublin is 32.4, while the average rate for the Leinster counties is about 22. The rate for Belfast is 31.5; for Ulster, including Belfast, 24.4.

I am sure every Irish medical man will agree with me in saying that the practices to which Dr. Taylor ascribes the fall in the birth-rate are unknown in Irish rural districts, exactly where the rate is lowest, and that in the cities, where it is highest, they cannot prevail to such an extent as to materially affect it.

I believe it would be found on examination that the same thing holds true for wide areas in Great Britain, and even in France and America, namely, that in these areas there is not so much a falling, as a permanent low natality due to causes among which the practices in question are conspicuously absent.

The birth-rate stated as a fraction per 1,000 of population is a striking example of the fallacy to which statistics so easily lend themselves. The number of both married and marriageable in a thousand persons is variable both as regards time

and place. If the number of persons under 20 and over 45 increase at any time or in any place relatively greater than those between these limits, the fact, as far as it goes, will mean a falling birth-rate. For example, I saw it stated in a late number of *Nature* that 50 per cent. of those born die before they reach 20. If, now, there being 14,647,783 of that age or under in the English population, 32,527,843 (1901), if there is ever so small an increase in the mass of life at 20 and under it will find marked representation in apparently lowering the birth-rate, and a relative increase in the number over 45 in proportion will have the same effect.

Primarily the rate is a potential function of the number of females between 20 and 40, that is, it depends on a numerical variable whatever other factors may intervene. Women under and over these ages bear children, and this, from a certain point of view, *i.e.*, as obtaining ultimate representation in vital status, is a most important fact. The number of children so borne being, however, negligible, the apparent form of the birth-rate can be, immediately, little affected by it.

Fall in the real birth-rate would follow only from women of the age period 20-40 bearing fewer children; it would be illicit reasoning to ascribe any such change to flux in the number of such women in a population undergoing variation. I am here only indicating necessary points for study; space would not allow me to discuss the variation in the number which has occurred in the United Kingdom. It is enough to say that Dr. Taylor's position, to be either strengthened or weakened, needs the variation in the relative number of child-bearing women to be taken into account.

The statistical form of the apparent birth-rate is the expression of variables lying, say, between the limits 30 and 20. Thus, while the birth-rate for Dublin is 32, that for many of the Irish counties is 20 or under. In general the rural is, and always has been, below the urban rate, and, therefore, if the urban population increases or the rural decreases, or both circumstances happen to concur, the apparent birth-rate may rise while the real, the relative number of children borne by women of age period 20-40, may be stationary or falling. The rise in the apparent rate for the United Kingdom beginning in 1840 actually concurred with a great increase in the urban population, that in which the real rate is highest, going with a decrease in the rural population, in which it is lowest. When, however, the rural population becomes relatively insignificant, as it has in the British Islands, or when the flux of population in favour of the high rate attains a maximum, the apparent birth-rate tends to

become stationary or even to fall. It is evident that a great increase in an element of population in which *ab initio* there is a high birth-rate cannot be taken as indicating a flux in the real birth-rate itself.

Apparent local birth-rates are worthless, as a rule, for purposes of inference unless they cover large numbers. Where they cover populations of, say, 100,000, discrepancies are to be noted from place to place which cannot be accounted for by the causes medical men, and Dr. Taylor in particular, assign from a limited point of view as determining relative natality. Recent change in the British birth-rate is probably due to a greater extent to the South African War than to the growth of the practices Dr. Taylor dwells on. In general, the rate, apparent and real, has been, in the main, determined by an impersonal non-volitional cause—*i.e.*, the growth of a great urban industrial class, a growth which varies with the well-being of the class. This vast increase of industrial life is an economic phenomenon almost mechanical in its nature, but it gives the importance of absolute mass to the personal equation; a greater mass of personal frailty and vice comes into the field to strike our minds. But the personal equation covers what works for good as well as what works for evil, and it may be doubtful in the first place that there is any relative increase in the mass of vice, and in the next place whether it is not compensated for by an increase in the mass of virtue or right conduct.

My object here is to insist that medical men should recognise the unity of vital status or bionomics, and not make desultory raids on it as political economists, clergymen and lawyers do from varying points of view. The economy of human life is the end or purpose of the economy of wealth, of morality and jurisprudence. The science of the production and distribution of wealth, morality, and jurisprudence are mere abstractions in themselves saturated in the actual field with the gross fallacies which attend deduction from the abstract. The concrete reality is human life, beginning with the life of the individual. To use a much abused term, theory, in the sense in which Coleridge uses it, we should aim at a theory, a mere true description of the actual nature of the life of the individual and how he actually maintains it by the formation and regulation of social aggregates, the regulation of his own conduct, the production and preservation of wealth, his means of subsistence, and so on.

Now the first fact that presents itself when such description is barely entered on is that the action of the individual is grossly at fault with reference to his primary object, the maintenance of his life; he is inconsequent, ignorant and irrational. For ages his mental ability to oppose the powers of Nature, to master, to use them, lay dormant. For ages he has allowed the devices originally arising to safeguard life and enhance its value to be turned against it. This fact is represented in the description or theory of human life. The moment man began to describe himself he fell into gross error and placed a bar in the way of describing himself in true terms, though these would be the simplest. He lied to himself, whether consciously or unconsciously does not matter, and became a slave to complex and contradictory systems of falsehood. He realised the powers of Nature as divine and remained their slave as long as he did. He described himself as a god, the descendant of a

god; he made his dead fathers and living kings gods, and in so doing built up interests which committed him deeper and deeper to falsehood.

But every fact could not be closed to true description, and truth in one direction led to a general perception of truth, by originating a method of pursuing it. Bionomics, limiting a term used in a wider sense to human life, not only remains barred in every direction by ancient error and the ideals and interests created by such error, but by the non-application of scientific method to its subject matter. "Compared," Alfred Wallace says, "with our astounding progress in physical science and its application, our system of government, of administrative justice and of national education, our entire social and moral organisation remains in a state of barbarism." It would be still more to the point to say that the mere description of our moral and social organisation remains in the "dense mists of half knowledge and speculation," and greatly in the hands of those whose interest it is that it shall remain so.

In a particular study of insanity in Ireland, referred to in an article in the *Westminster Review* (March, 1903), I took in a continuous area all the permanent families and investigated their life history as far as I could go. I found at once that the method carried me far beyond my particular study, among other matters to the birth-rate and marriage in connection with it. In 400 families only in one instance had I reason to suspect the practices Dr. Taylor refers to. In 217 births I found only 5 to be illegitimate; in one of these last the mother was a weak-minded girl; the other four did not belong to my permanent families; were, indeed, servant girls. The apparent birth-rate for the area (1901) was 17 per 1,000; it had fallen within thirty years from 28, and is falling every year, or rather fluctuating wildly, as must be the case where small numbers are under observation. It would take periods of ten years at least to show the fall beyond doubt. The only practices used to prevent child-bearing are protraction of the period of lactation and absolute continence in married life. The last, I believe, is more common than is generally supposed, particularly among the elderly. Ill-health, abnormal states of the uterus and ovaries short of pronounced disease, sexual indifference and personal indifference amounting often to positive dislike, are by no means negligible factors and increase with age of marriage.

Other points of even greater weight occurred to me in this study. My object here is, however, not to give my conclusions but to show that wide and careful observation of the *personnel* of family life is the essential base of human bionomics and that that observation is peculiarly within the province of the practising physician. It seems to me that both Dr. Taylor and his critics have a far finer field for such observation than I have, but forsake it for crude statistics and the inconsequent morality cherished in another profession. What is the use of trotting out potential fecundity, the Malthusian bugbear, when it is a ghost even to herrings? I would leave Count Tolstoi to condemn marriage as an immoral and improper institution, the clergy and lawyers to taboo illegitimacy and excuse celibacy only when they practise it. What are we the wiser when we find Mill and his disciples declaiming against early and improvident, and physiologists against deferred and provident, marriages? We are left in a state of senseless

muddle, left worse even than the mindless creatures of convention and custom who, at least, have something to go by. But the field of actual circumstance is open before us, we know the method of scientific investigation, and surely we ought to know that until we enter it with that method we must remain in the dense mists of half knowledge and speculation.

## ACETOZONE :

### A NOTE ON ITS VALUE AS AN ANTISEPTIC AND GERMICIDE.

By JAMES BURNET, M.A., M.B., M.R.C.P. Edin.,

Clinical Tutor, Extramural Wards, Royal Infirmary; Registrar, Royal Hospital for Sick Children; and Physician to the Marshall Street Dispensary, Edinburgh.

This chemical compound was brought to the notice of the profession in this country about two years ago, although it had already been successfully used for some time in America. The chemical title for this substance is benzoyl-acetyl-peroxide, and its formula may be expressed as  $C_6H_5CoOOC_2H_5$ . Benzozone was the term at first applied to it, but as this closely resembled the names of other antiseptics already in use, it was soon altered to acetozone. Novy and Freer, of the University of Michigan, carried out a series of observations upon the action of a number of organic peroxides on bacteria. They called attention to the fact that acetozone, which is one of these peroxides, when brought into contact with water, splits up, giving rise to the peroxides of acetyl hydrogen and benzoyl hydrogen. These peroxides, when in solution, are very energetic, and act powerfully as germicides. It was claimed for acetozone that it was probably the most powerful bactericidal agent in existence.

A few preliminary remarks on the nature and properties of this substance may not be amiss. Acetozone occurs in the form of fine acicular crystals, and melts at the ordinary body temperature. If heated suddenly decomposition takes place almost instantaneously, and an explosion may result. It is soluble to a small extent in oils, slightly so in alcohol, and fairly soluble in ether and in chloroform. In water its solubility varies from 1 : 1,000 to 1 : 10,000, according to temperature and other circumstances. Alkalies and all forms of organic matter readily decompose it. It is marketed as a powder consisting of equal parts of itself and another inert, absorbent substance. In this form it may be handled with the greatest freedom. As regards its germicidal power, it is stated to be very much more active than corrosive sublimate, while at the same time it is non-toxic, and may be freely administered internally in aqueous solutions.

My methods of employing acetozone were two in number. Most frequently it was used as a watery solution containing  $2\frac{1}{2}$  grains to every four ounces. After thoroughly agitating there resulted a hazy solution, and this was employed almost immediately after its preparation and never later than 48 hours. Occasionally, I found the addition of one part of acetozone to 250 parts of talc—*i.e.*, about one grain to the half ounce—very useful as a dusting powder. I have made use of acetozone in something like sixty cases, and always with the most satisfactory results. Already I have communicated a note on acetozone to another journal, (a) but further experi-

ence of its value warrants me, I think, in publishing the results of my more extended observations in order that others may benefit thereby. The cases in which acetozone was employed, and of which I kept a record, number fifty-three in all. They were of a most varied description, ranging from whitlows and septic wounds to actual gangrene. It is, of course, absolutely impossible to publish notes of all these cases. There are, however, two very interesting clinical histories which I may briefly place on record.

One of the earliest uses to which I put acetozone was in the case of a child of five years. The little finger of his left hand had been severely crushed and lacerated by being trampled on by another boy while at play. He was brought to me immediately after the accident. The finger was split right up the middle of its palmar aspect, and the flaps thus formed were covered with mud and dirt. The terminal phalanx was broken. The parts were first carefully washed with acetozone solution (5 grs. : 8 ozs.). The finger was then dressed with lint wrung out of the lotion and covered over with gutta-percha tissue. The whole hand was then placed on a splint and absorbent cotton wool and a bandage applied. Next morning, when the dressings were removed, the soft parts were quite black and cold. They smelt badly, and seemed as if about to become gangrenous. Nevertheless, the finger was kept in a small basin containing a solution of acetozone for fully fifteen minutes. I then further bathed the parts very carefully and reapplied the dressings. This process was repeated again the same evening. On the third day the parts presented a healthier appearance, and had to some extent lost their former evil odour. The wound was dressed three times. On the fourth morning the gangrenous appearance was almost entirely gone, and the tissues when pressed bled quite freely. Wet dressings were continued until the sixth day, when they were withdrawn altogether, and a dusting powder consisting of acetozone and zinc oxide (2 grs. :  $\frac{1}{2}$  oz.) was freely applied. This, however, caused considerable burning and smarting pain, and consequently the amount of acetozone was reduced by one-half. On the eighth day, as the granulations which were now beginning to spring up were still raw and fresh, they were gently scraped and the flaps brought together by means of a couple of horsehair sutures. The parts were then dusted over with the powder as before. There had been too great delay in bringing the flaps into apposition, and consequently the tissues towards the finger tips refused to be connected, so that this portion remained as a raw, granulating surface. I was, however, afraid to use sutures earlier lest their tension might lead to suppuration in a wound which was by no means healthy-looking to commence with. At the end of a fortnight the finger was practically healed, except the small piece at the tip. The fracture of the terminal phalanx had united, and the child had no longer an ugly, unshapely finger such as had been anticipated. The mother, however, was told to continue dressing it for a short time. Unfortunately, in spite of my instructions to move the joints regularly, she neglected to do so; and consequently, though the child's finger is perfect so far as shape goes, it will presumably always remain stiff and flexed. This is a case where amputation at first seemed almost inevitable, and, indeed, there was no small risk incurred

(a) *The Medical Times*, October 18th, 1902.

in thus temporising with a finger in such a septic and gangrenous-like condition.

The second case to which I wish to refer, and which is of more than passing interest, is that of a woman, *æt.* 49. She had some pain in the left forefinger. She imagined the condition to be a commencing whitlow, and applied a piece of lint soaked in pure carbolic acid, covering it over with gutta-percha tissue. This dressing was kept on from Friday morning till late on Saturday afternoon. As she felt the finger cold and numb she removed the dressing, and to her surprise found the finger purplish-black in colour from its tip right up to the middle of the second phalanx. I was accordingly sent for, and found the parts quite anæsthetic. On pushing a needle deeply into the finger at different places no blood oozed out. In other words, the patient was suffering from the condition known as carbolic gangrene. Moist dressings of acetozone were applied and the finger well covered up with a thick wrapping of cotton-wool. The patient passed a restless night. She had great pain over the second phalanx of the affected finger. In the morning, on removing the dressings, it was noted that a fairly well marked line of demarcation was already beginning to form. I placed the finger in a solution of acetozone, and kept it there for fully half an hour. The moist dressings were then reapplied. This process was repeated in the afternoon, and again in the evening. Next morning, the patient experienced sensation slightly over the second and to some extent also over the third phalanx. When these parts were pricked with a needle bright red blood oozed out. The treatment with acetozone was kept up for a week, and at the end of that time only the very tip of the finger remained anæsthetic. The skin



over the other parts was beginning to assume a more natural appearance. The parts about the terminal phalanx, however, still looked far from healthy, and although it was now evident that amputation of the finger was no longer called for, it was thought that in all probability the terminal phalanx, or at least part of it, would eventually perish. In the course of a few weeks all the unhealthy skin and most of the underlying soft parts

were removed, and the remaining tissues kept constantly under the influence of acetozone. Finally, the bulk of the nail was taken off, leaving only the matrix behind. The photograph shows very well the condition of the finger two months after the commencement of treatment. After the finger was photographed the projecting part of the terminal phalanx was removed, and at the present time the patient has as perfect a finger as she could well wish for. Its movements are not at all impaired, and the fact that it is slightly shorter than the corresponding one of the other hand is scarcely noticeable. This case proves the possibility of treating carbolic gangrene without amputation.

I have mentioned these two cases in some detail because they were serious ones, at all events they involved the probable loss of a finger. Acetozone, however, has been chiefly employed in the treatment of ordinary affections such as whitlows, abscesses, and small septic wounds in general. After freely incising a whitlow or other abscess the application of moist acetozone dressings brings about a rapid cure, and this mode of treatment is, moreover, devoid of the risks involved where carbolic acid or lysol is used. So, too, with boils and carbuncles. Abscesses, even when extensive, cause little trouble if, after incising them and squeezing out the purulent contents, the cavity is flushed out with acetozone solution, and then stuffed with gauze saturated with the same. Wounds which are already septic speedily become healthy when dressed with lint wrung out of a watery solution of acetozone and covered over with gutta-percha tissue.

In a case of cystitis due to urethral stricture, acetozone was found of great value. The patient was 50 years of age, and had a very tight stricture. To relieve this he had been passing, or at least attempting to pass, a very septic-looking gum-elastic catheter. After relieving the stricture the cystitis remained. Many internal remedies were used for its relief, but these only gave slight results. Accordingly the bladder was thoroughly washed out with a weak solution of acetozone. This was followed by marked improvement. A week later the washing-out process was repeated, and from that time the cystitis rapidly disappeared. So far as I am aware, acetozone has never been used in this way before, and consequently it might be worth trying in similar cases. In this patient's case it certainly had a very definite and speedy effect. This leads me to suppose that acetozone would be valuable in puerperal septicæmia. It might not only be used as an intra-uterine douche in such cases, but might also be given internally in the hope that it might thus counteract the evil effects of the toxins circulating in the blood. Already it has been used with some success in appendicitis, as well as in dysentery and in enteric fever; and elsewhere I suggested its use as an intestinal antiseptic in cholera and in tuberculous affections.

There are one or two points which must be carefully noted in using acetozone. If used in too great strengths it causes considerable smarting and pain. On the other hand, it may, within certain limits, be administered internally in comparatively large amounts. In fact, to obtain good results from its internal administration acetozone must be given freely and in heroic doses. This is especially so in cases of enteric fever. Solutions

should always be freshly prepared, and only water should be used as a solvent. I do not think the action is quite so powerful when hot water is employed in making the solution as when cold is made use of. I noticed, at all events on several occasions, that when a standard solution had been prepared and before use was diluted to the necessary strength with hot water the results obtained, so far as therapeutic effect was concerned, were not quite so good as when the dilution was made with cold water. The reason may be that hot water causes too rapid a disintegration of this compound. So far as my experience goes acetozone may be stated to have no deleterious effect on metal instruments. Its very pleasant odour is another recommendation of no little consequence in many instances. Time alone forbids a further consideration of the many possibilities of this new preparation, but these imperfect notes may serve as an introduction to those as yet unacquainted with the virtues of this antiseptic and germicide.

### A CASE OF SUPPURATIVE KNEE-JOINT.

By A. R. BRACKETT, M.A., M.D.

R. J., æt. 10, family history good, robust, healthy boy. While playing marbles on the floor, thrust into his knee-joint a needle which lay unobserved upon the floor. The needle was threaded with about six or eight inches of ordinary black cotton thread. It penetrated the joint eye first, carrying the thread with it. The joint was penetrated on its internal aspect, about one and three-fourths inches posterior to the patella, the needle breaking in two pieces, the larger of which was withdrawn at once. The smaller portion with the eye remained in the joint, the ends of the thread which it carried hanging out several inches. At the request of the child, "because it pulled," the mother cut the threads flush with the skin, allowing the remaining part of the thread attached to the needle (which proved to be over two inches long) to disappear under the skin, thus transforming the proposition to a "hunt for a needle in a haystack." Infection promptly occurred. At the end of a week, when called to see the case in consultation, the child was suffering from an intensely septic synovitis, decided general toxæmia, and great pain. The temperature stood at 104½° F. Pulse, 130; respirations were correspondingly rapid, but were not counted; had had several chills, followed by sweating.

Operation was advised at once, but the practitioner in charge objected. The parents, however, becoming alarmed, brought him to the hospital the following day. Before operating an X-ray picture was secured, both in the antero-posterior axis of the limb and in the lateral axis. The shadow of the needle fragment was readily seen. Taking the planes shown by these two pictures as a guide, the joint was freely opened, first on the internal aspect. By good fortune our first incision came within the width of a knife blade of the foreign body, exposing also a portion of the thread. Following this up made the fragment of needle easy to find. It was imbedded nearly a quarter of an inch in the internal condyle of the femur. After its removal the joint, which was full of pus, was opened on the external surface by an incision parallel to, and equal in length (about three and a half inches), to the opposite one; with a dull periosteotome the patella was elevated sufficiently to allow of complete through-and-through irrigation of the joint. This was done with dioxygen, pure, and repeated until the reaction was very slight. Drainage-tubes were inserted, plain gauze dressing applied, thickly covered with absorbent cotton, fixation secured by a fenestrated splint, and the patient put to bed.

His temperature rapidly came down, his pulse also; pain ceased except when limb was moved. The following morning the temperature by rectum was 99° F.,

pulse 90. The knee was uncovered, and a second thorough irrigation of the joint was made. At the end of seventy-two hours, temperature and pulse were entirely normal, and the little fellow was begging for food, and to be allowed to get up. The drainage-tubes were now removed, the sutures that had been inserted but not tied were drawn together, closing the wound, not, however, without some misgiving as to the possibility that re-opening and re-draining might be necessary. Our fears were groundless, for primary union promptly followed. In ten days the little patient was out of bed and the splints removed; on the sixteenth day, in spite of orders to the contrary, the patient walked some distance from the hospital with a very slight limp; on the eighteenth day he went home. Now, two years after the injury, he has a flexible and perfect knee-joint. The infection in this case was prompt in developing and virulent in its character, manifested both locally and constitutionally, consequently our prognosis could not be other than unfavourable. Under such conditions a "stiff knee-joint" would ordinarily be considered a good result. That we did not have such a result is due to two factors: First, the thorough drainage established; and second, to the equally thorough and beneficent action of the antiseptic solution that was used. I am by no means tied to any one technique nor to any one of the many antiseptic preparations that have become, so to speak, classic. But after a fairly extensive experience covering a number of years, I am unable to name any reagent that can so satisfactorily accomplish what is demanded of it as dioxygen. Other reagents are germicidal, but they are also toxic. They accomplish antiseptis, it is true, but they are more or less irritating and frequently, as in the case of "corrosive sublimate" so commonly used, have a destructive action on the cellular structures in living tissue, even to the extent of a superficial necrosis. Many of them are disagreeable in odour, consequently distasteful to patients—no unimportant factor in the presence of sensitive stomachs and pain-racked nerves. None of them develop by their action a "mechanical force" (if we may use the term) that materially assists in dislodging and clearing out ingrained particles of infectious substances, as seen in the bubbling of applied dioxygen, which is non-toxic, non-irritating, and germicidal. In giving off its oxygen it seems really to vivify the structures with which it is brought in contact and hasten constructive metabolism.

### THYROID GRAFTING IN HUMAN BEINGS.

By H. CHRISTIANI, M.D.;

Professor at the Faculty of Medicine of Geneva.

THE attempts at thyroid grafting hitherto performed in man may be divided into two distinct groups, *e.g.*, heterothyroid grafts, that is to say, the transplantation of thyroid grafts from animals to man, and homo-thyroid grafts, *viz.*, transplantation of human thyroid gland.

Most of the experiments in the direction of transplanting thyroid grafts from animals to man have been done with sheep's thyroid, following the example set by Sir Victor Horsley. An entire lobe or large portions of the gland are removed from the animal and are buried in the connective tissue of this or that region. All these experiments gave immediate good results, but in all, after a variable space of time, the thyroid tissue showed signs of atrophy, the longest period being two months.

Grafts of human thyroid were made in 1883 by M. Kocher and others, the material having been obtained for the most part from human thyroid glands that had been extirpated. The results of this method of implantation were not, on the whole, more favourable than those obtained by grafts of animal thyroids.

These results offered so little encouragement that certain observers recently engaged in the problem of

thyroid medication have been tempted to relegate thyroid implantation to the limbo of impracticable therapeutical projects.

Nevertheless, if we review all these experimental investigations and compare the results of direct experiment, we find ourselves in a position to draw conclusions somewhat less negative in character. It must be admitted that Shiff's experiments in thyroid implantation, which were the starting-point of this line of research, yielded no persistent results, and various physiologists, pursuing the same line, were not more fortunate. When, fifteen years ago, I first took up the study of the thyroid gland, the general opinion was that the transplanted gland would either undergo necrosis and speedy absorption or grow for a time, only to disappear later on—invariably in a comparatively short space of time—by slow atrophy.

But in these investigations the anatomical factor seems to have been lost sight of, attention having been directed exclusively to the physiological side of the question. Von Eiselsberg was the first to show, not only that thyroid grafts in ecthyroidised animals might save life, but also that the transplanted thyroid was capable of maintaining its distinctive structure. My earliest observations, published at about the same time, confirmed Eiselsberg's researches, and more recent investigations demonstrate conclusively that it is possible to obtain permanent grafts and, incidentally, to explain why previous grafts had failed to gain a stable footing. It thus became possible to formulate certain rules to be observed in practising these grafts, rules which we are fain to observe under penalty of failure. It is unnecessary here to give details, but these rules may be summarised as follows: (1) The graft must be homothyroid; (2) only normal living tissue must be transplanted; and (3) small multiple grafts should be made, taking care to implant them in very vascular regions. By following these rules I have been uniformly successful in obtaining positive and durable results both from the anatomical and the physiological points of view. When, on the contrary, I transplanted the thyroid tissue of an animal belonging to a different species, I invariably noted more or less prompt cytolysis, with disappearance of the graft. Similarly, if the graft were dead or had undergone changes, it was rapidly phagocytosised, destroyed, and absorbed.

If the thyroid fragment be too large, we usually find a more or less extensive zone of necrosis at the centre which cannot possibly undergo regeneration; moreover, the sclerotic process which sets in may jeopardise the vitality of the portion of the graft which has so far maintained its vitality. It is also very important at the time of making the graft to form a clear idea of the approximate requirements of the organism in the matter of thyroid function. If this requirement be non-existent, as in the case of an animal possessed of a normal gland, the graft may take, but its vitality will be low in accordance with the principle that all useless organs undergo atrophy.

In animals partially ethyroidised, the grafts readily take root and manifest remarkable vitality with a tendency to hypertrophy, whereas in animals whose thyroid requirements are too pronounced (as from total thyroidectomy at one sitting), especially if only small grafts are made, these grafts run the risk of being subjected to an excessive strain from the onset. Inasmuch as, at the commencement, that is to say, soon after transplantation, the regeneration of these "neothyroids" is necessarily incomplete, their embryonic vascularity falls short of requirements, consequently these neo-organs may succumb to the burden thrown upon them, and, instead of the characteristic thyroid hypertrophy we may get signs of degenerative lesions with consequent sclerosis and atrophy.

When we pass from the experimental to the clinical domain, other difficulties present themselves. In animals we usually transplant grafts of normal thyroid tissue to normal animals or animals who have been deprived of a part or of the whole of their thyroid gland. This was not always the case in the experiments of grafting in human beings. The persons in whom the grafts were made were, on the contrary,

usually suffering from the effects of partial or total destruction of the thyroid gland.

Now it must be borne in mind that if we practise transplantation on organisms completely deprived of thyroid gland it may happen, especially if the grafts be small in size and few in number, that they fall victims to the fate that overtakes experimental grafts made under similar conditions (overstrain and degeneration). Moreover, it may be that disturbances of general nutrition render the tissues of the organism unsuitable to act as graft beds; the tissues of myxœdematous patients, for instance, are often ill-adapted to the purpose of graft reception.

In addition to the numerous difficulties that present themselves in the attempt to graft the thyroid in man there is another, not the least important, *viz.*, the difficulty of obtaining normal human thyroid substance. It is obviously of the greatest importance to utilise histologically normal gland for our grafts, since those who have so far employed human grafts have invariably made use of altered thyroid tissue—grafts of goitrous gland, for instance—and the pathological characters of the thyroid grafts may not have been altogether foreign to the failures.

In order to protect ourselves against these numerous sources of error, and in order to avoid, in the study of therapeutical thyroid grafts, the groping inseparable from the empirical methods hitherto followed in investigations of this kind, I have systematically proceeded on scientific lines just as in my experimental researches. The first point to establish was whether normal thyroid tissue could be successfully grafted in man. Considerable time elapsed before I could verify this possibility; indeed, it was not until an opportunity occurred in M. Kummer's service in the course of a deep operation on the neck of a girl that I was enabled to place under the skin two small fragments of normal thyroid gland. These two small implantations proved a valuable starting-point for my subsequent attempts at implantation in man.

We next investigated the fate of different human thyroid tissues, normal and diseased, when grafted on diseased organisms, hyper- or dysthyroidian. At the onset we met with certain difficulties, not that the patients objected to such grafts, for they are usually perfectly willing to consent to any measure which holds out promise of ameliorating their unhappy plight, and even to provide the thyroid grafts themselves; but the real difficulty was to study the ultimate fate of these grafts. Nevertheless, we managed to investigate the course of a series of grafts of different kinds, and to examine some of them after extirpation. Each of the patients having received a number of grafts, there could be no objection to our subsequently removing one or two.

Here, briefly narrated, are the three observations on which our conclusions are based:—A girl, *æt.* 20, who underwent an operation on the neck for a non-thyroidal affection and whose gland was found to be normal, provided the grafts, made on September 19th, 1902, one on herself in the supra-clavicular fossa and two on the following patient.

A myxœdematous boy, *æt.* about 12, presented in the region of the left thyroid body a small friable goitre, of a whitish tint on section. This had been extirpated. The left lobe was small, pale, and its consistence resembled that of the goitrous lobe. He was grafted (1) with the normal thyroid body of the girl just referred to; (2) with thyroid substance from the next patient; and (3) with fragments of the left lobe of his own thyroid.

The next patient was a woman, *æt.* 34, in good health in spite of the fact that she had a goitre on the left side, which was extirpated, while the right lobe appeared to have undergone little change. Two series of grafts were made in this case—(1) with the right lobe of her own thyroid, and (2) with the left thyroid lobe of the previous patient.

For the purpose of these grafts, then, we made use of three classes of thyroid: first, normal thyroid substance (first patient); slightly altered substance (third patient); and manifestly altered as in the third



case. The recipient organisms were normal as in first case, apparently normal as in second case, distinctly diseased as in third case. By combining these different elements our grafts paved the way to the following eventualities:—(1) Graft of normal thyroid substance in a normal organism; (2) graft of thyroid tissue manifestly altered in a normal organism; (3) graft of thyroid tissue apparently but slightly altered in an apparently normal organism; (4) graft of normal thyroid tissue in an organism clearly diseased; (5) graft of manifestly diseased thyroid tissue in a manifestly diseased organism; and (6) graft of slightly changed thyroid tissue in a manifestly diseased organism.

Six months later I removed from the first patient, the girl, one of the grafts made with her own thyroid (first eventuality). Two months later we removed from the lad, our second patient, grafts from the third patient (sixth eventuality); and fifteen months after we removed from the last-mentioned grafts of her own thyroid (third eventuality). These fragments were subjected to histological examination with the following results:—

*Normal Thyroid Graft in Normal Organism.*—Microscopical examination of this graft demonstrated that the neo-thyroid organ possessed the same structure as the original gland. The alveoli were large, within proper limits, and were filled with colloid substance. Vascularisation was normal, and the neo-vascular formations presented the appearance of stability. No trace of infiltration such as one meets with in young grafts nor of the degeneration or atrophy met with in grafts which are undergoing absorption. We found, in short, that a thyroid graft of normal gland in a normal organism, six months later presented all the appearances and characteristics of normal thyroid gland.

*Graft of Slightly-Changed Thyroid Tissue in an Apparently Normal Organism.*—When the graft was made the tissue did not present a normal structure, there being obvious, though not very advanced, lesions, e.g., dilatation of the follicles, resulting in some parts in coalescence of the alveoli. The grafts were taken from the periphery of the organ and included fragments of the capsule. Removed and examined fifteen months later, its structure presented a closer resemblance to normal thyroid gland than did the original graft, but in the adult alveoli some epithelial buds were seen similar to those met with in grafts undergoing development or hypertrophy. We find then that thyroid tissue which is distinctly not normal but does not present grave structural changes may, when grafted, not only give birth to neo-thyroids capable of persistent vitality, but may undergo a process of progressive metamorphosis which tends to bring back the changed thyroid structure to that of the normal gland.

*Graft of Slightly-Changed Thyroid on a Manifestly Diseased Organism.*—The graft was two months old, and presented a frankly thyroid appearance, but the alveoli were small and contained comparatively little colloid substance. There was some inflammatory infiltration in the perialveolar connective tissue which, however, did not differ from that often met with in experimental grafts performed under normal conditions. In any event it was noted that the grafted tissue had undergone certain modifications, and, as in the preceding observation, in the direction of restoration to the normal gland structure.

It should be added that in this case the recipient organism, in spite of the large number of grafts (seventeen, of which eight were taken from the pathological thyroid, which probably all underwent atrophy), had not received the quantity of thyroid tissue necessary to the proper discharge of the function. The relatively less vitality of the grafts in this subject may possibly be explained by the myxœdematous state of the tissues, which diminished their aptitude to nourish the implanted tissue, and also to a sort of overstrain of the young grafts imposed before they had undergone complete development. Nevertheless, both mentally and physically, the subject, last seen upwards of three years after the operation, presented a remarkable improve-

ment. He had grown and his intelligence was markedly greater.

The grafts of manifestly-changed thyroid tissue in an apparently normal organism (second eventuality), and grafts of the same manifestly-changed tissue in an obviously diseased organism (fifth eventuality), could not be identified two months after implantation. Admitting that the discovery of these grafts presents considerable difficulty, so that it cannot be positively asserted that these grafts had actually undergone absorption, their disappearance in both these observations—the enfeebled vitality of the engrafted tissue and its obviously pathological structure—render this hypothesis plausible.

By grouping the facts just stated we justify the conclusion that thyroid grafts are possible in man, and that by this means we can obtain permanent neo-thyroid glands. The results from an anatomical point of view are excellent, provided normal gland be employed; they are positive even when moderately changed gland substance is employed as in cases of slight goitrous degeneration. They are negative, on the other hand, when obviously diseased gland is used, and further observation will be required to establish within what limits goitrous tissue may be employed with this object in view.

From a clinical point of view we may conclude that the preventive thyroid graft, that is to say, a graft made in cases where, after too radical extirpation of the organ, the subject is threatened with cachexia strumipriva, may avert the impending manifestations. In idiopathic myxœdematous hypothyroidea grafts are equally apt to develop and persist, provided always that the tissues employed have not undergone too marked changes.

In the present state of our knowledge it would be imprudent to dogmatise upon the clinical value of this procedure, which will only command general assent after years of observation in numerous similar cases. But since experiments on animals show that the thyroid organ, when it persists with its normal histological characters, is perfectly capable of fulfilling the function, there is no obvious reason to question the probability of a similar result when it persists in man.

Thyroid grafting, then, deserves to be withdrawn from the obscurity into which it has been allowed to fall, for, carried out with due regard to technical requirements, it may once again acquire a position among thyroidal medications, among which, indeed, it is quite possible it may one day occupy a foremost place.

Our researches, so far as they go, authorise the hope that we may be enabled to simplify the procedure so as to place it within reach of practitioners in general. We are working with the two-fold object of avoiding the transplantation from body to body, a manoeuvre which is not free from drawbacks, and to facilitate the implantation by depriving it of the character of a surgical operation.

With the object of avoiding the immediate transplantation of the organ from the donor to the recipient we have investigated the preservation of thyroid tissue in various liquids and, so far as they go, these researches tend to show that this preservation, at any rate in respect of the thyroid of the rat and the rabbit, is possible in artificial serum and in the blood serum of certain animals, but only for a comparatively short period of time (rather under an hour instead of ten seconds in the air). Our latest observations justify the inference that ere long it may become possible to prolong this period in a marked degree.

With regard to the simplification of the implantation we propose, at M. Kummer's suggestion, to intercalate portions of thyroid gland without the necessity for cutaneous incision. Thyroid tissue, reduced into very small fragments, by the aid of a sharp knife and with every precaution to avoid crushing, which would destroy its vitality, may, so to speak, be emulsified in the preservative liquid and injected into the selected organism through a trocar or large hollow needle. These experiments, which are still in progress, have not as yet given results sufficiently conclusive to allow of our formulating a definite conclusion. In any event,

it is evident that if we are successful in rendering this procedure practicable the operation of grafting will become hardly more complicated than an ordinary injection of serum.

Whatever be the future of this procedure it is not to be supposed that it will ever absolutely take the place of palliative thyroid medication. Not only does the latter method of treatment remain indicated in cases where grafting is impracticable, but it may be required as a preliminary step to grafting, in order to prepare the soil, in presence of grave disturbances of nutrition, and indirectly to assist in the development of the transplanted thyroid tissue by avoiding the risks inherent to too early and exaggerated functional demands.

### The Out-Patient Departments.

#### GREAT NORTHERN CENTRAL HOSPITAL.

Medical Cases under the Care of H. W. SYERS, M.A., M.D.

CASE I.—A boy, *æt.* 9.—The history was that the child had been in his usual good health until ten days before he was brought to the hospital. At that time he was somewhat indisposed, but the symptoms were mainly those of gastric derangement and caused no anxiety. His skin was noticed to be rather hot when put to bed just nine days before he was seen, and he slept badly. Next day, on rising, it was found that the right upper extremity was paralysed. He was unable to move the limb at the shoulder-joint in any way whatever, and, in fact, the only movements which could be effected were those of pronation and supination of the fore-arm, together with flexion and extension of the fingers. The febrile symptoms rapidly disappeared, and nothing abnormal remained except the loss of power already described. The sphincters were not affected, and no pain was complained of, except some slight discomfort in the affected limb and trifling stiff neck on the right side. The child was somewhat pale, but fairly nourished. The right upper limb hung quite helpless at the side of the body. There was not the smallest power of moving it at the shoulder or elbow-joint. The muscles of the fore-arm generally were soft and flaccid and were apparently slightly wasted. The grasp of that hand was almost *nil*. Sensation was perfectly normal all over the paralysed limb. No response could be obtained from the elbow and wrist taps. The lower portions of the trapezius and the serratus magnus muscles were also affected, and the angle of the right scapula was unduly prominent, especially when the limb was lifted up above the head. There was no evidence of loss of power in any muscles other than those referred to. The gait was perfectly normal, and all movements could be performed, both as regards the left upper extremity, the trunk and the lower limbs, yet the knee-jerk was absent on both sides. The affected limb was very slightly colder than that of the opposite side. No vaso-motor changes could be made out.

Dr. Syers pointed out that all the muscles supplied by the brachial plexus were to a greater or lesser extent involved, and he diagnosed the case as one of anterior poliomyelitis, in which the symptoms were limited to one limb, and that alone. Such cases, he remarked, were decidedly rare, as in the great majority of instances the malady selected certain muscles or groups of muscles, passing over others, and also involved more than one limb, being sometimes of a hemiplegic type, or affecting one lower extremity and the upper limb of the opposite side.

CASE II.—The patient, a boy, *æt.* 6, was brought to the hospital with the following history:—He had been in good health until about a week before being seen. At that time, and without apparent cause, he first complained of pain in the abdomen, chiefly about the umbilical region. The pain was not increased on pressure, and, as far as could be gathered, was of a colicky nature. There was slight diarrhoea, the bowels acting two or three times a day, and there was loss of appetite. There was no cough, and no history was

given of any symptoms pointing to chest disease being present. The condition remained the same, constant gripping pain being complained of, until the patient was brought to hospital.

The child was well grown and well nourished. A most careful examination of the abdomen revealed no abnormality whatever; the wall of the abdomen was flaccid, and nothing in the nature of a mass could be felt anywhere. It was obvious that the mischief was not situated in the abdominal cavity, and the facial aspect was strongly indicative of thoracic disease. The face was somewhat dusky, the *alæ nasi* moving slightly during respiration, and the child was distinctly short of breath. Physical examination revealed the fact of the presence of a considerable pleural effusion at the right base, where there was marked dullness on percussion, and the breath-sounds, though by no means lost, were yet distinctly more feeble than on the left side. The temperature was 101°.

Dr. Syers remarked upon the great importance of this case. He emphasised the fact that the history and symptoms are not infrequently most misleading in the case of young children, and the present case proved this in a very marked fashion. Everything in the history of the child's illness pointed to the lesion being situated in the abdomen, and there was absolutely nothing to lead to the suspicion that the case was one of pleural effusion. The practical deduction to be drawn from this case was pointed out by Dr. Syers, and it was that never, under any circumstances, should an examination of the whole of the organs and systems be neglected, and this especially in children. If this be not done, disaster will certainly ensue either sooner or later.

The tendency of symptoms to be referred to a distance is by no means unusual in children, and this should ever be borne in mind. It was found that the right pleural cavity was practically filled with clear fluid.

CASE III.—The patient, a boy, *æt.* 6. His illness had commenced a year and a half before being seen. The first symptom was a weakness of gait and a tendency to stumble. This had continued, and had become more marked. In other respects the child had remained in his usual health. There was no family history of nervous or other disease.

The child was rather pallid, but not unhealthy-looking. His gait was peculiar; the legs were widely separated, and in walking he swayed from side to side, the movements of progression being feebly performed. The upper limbs were quite healthy, all their movements being normal. The muscles of the lower extremities, with the exception of those of the calves, were considerably wasted and flabby. This was especially marked as regards the thigh muscles. The knee-jerks could not be obtained. The calf-muscles were considerably increased in size, and were abnormally hard and firm to the grasp. The increase in size was quite obvious, even on superficial examination.

Dr. Syers pointed out that the case was an instance of that rare malady, pseudo-hypertrophic paralysis. He called attention to the wasting of the muscles of the lower extremities, with the exception of those of the calves, and remarked that the diagnosis would be confirmed by placing the child on the ground and observing if he assumed the erect posture in the manner which is so characteristic of this disease. The child was placed flat upon the ground, and the manœuvres which are decisive of the existence of pseudo-hypertrophic paralysis were carried out in a perfectly typical manner.

### British Health Resorts.

#### VI.—MULLION (CORNWALL).

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

MULLION has long been prized by the favoured few as one of the most delightful of Cornwall's many charming health and holiday stations. Through the enter-

prise of the Great Western Railway it has now been rendered easily accessible. Mullion is situated on the eastern side of the famous Mount's Bay, that great natural recess on the southernmost boundary of "The Delectable Duchy." The nearest railway station is Helston, some eight miles distant. The drive from Helston to Mullion along Cornish lanes crowded with a rich and varied flora is peculiarly attractive. An omnibus runs between the two places, and now travellers may journey rapidly and comfortably by motor car.

Mullion is a simple little rural district, picturesque and peaceful, offering opportunities for a "rest cure" particularly needful for the jaded brain-worker and wearied town-dweller. It is an ideal resort for the recuperation of brain and nerve. Convalescents, invalids and delicate adults will here find much that is healing and health-reviving.

Climatically, it offers many advantages. In winter the climate is exceptionally mild, due, doubtless, in great measure to the influence of the Gulf Stream. In summer, invigorating breezes supply a bracing character which is absent in many of the southern resorts of the county. We have been favoured with special meteorological returns of the district taken in 1899, from which it appears that the average temperature in winter is 46° 89', in spring, 52° 34', and in summer, 59° 92', the mean daily range for the whole year being 9° 29'. In the winter, November to February inclusive, 290° 6 hours of sunshine were registered; in the spring, March to June, inclusive, 871° 39 hours; and in summer, July to October, inclusive, 941° 52 hours. The total rainfall is given as 28° 61 inches; 15° 32 in winter; 5° 67 in spring; and 7° 62 in summer.

Mullion offers many delights for the artist and naturalist. Admirable golf links are near at hand. The vigorous will find ample opportunities for sea bathing, boating, sea fishing and other sport. The neighbouring country is well suited for driving and cycling, and offers endless charms for the pedestrian.

In the immediate neighbourhood there are numerous attractions. The district is particularly fine in its natural rugged sea-coast outline, the cliffs are bold and imposing, and the grandeur of the rolling sea will forcibly appeal to many. The psychological influence of this district should be known to physicians. There are many cases needing the mental stimulus which Mullion can so well supply.

This is not a resort for the fashion-loving invalid, but a peaceful retreat for Nature's true lover. The visitor needing constant medical attention will choose some well-known spa or journey to a much-advertised town resort; but the patient requiring simply a hygienic environment and restful mental life will find all that can be desired in this somewhat isolated land of enchantment in the Lizard.

The visitor will obtain excellent accommodation at the Polurrian and Poldu Hotels, both admirably conducted under the same management. The former is situated immediately above Polurrian Cove, from whence good views of Mullion Island may be obtained. The island is of much interest to geologist and ornithologist. Poldu Hotel is situated on the cliffs within sight and sound of the invigorating sea. It is of modern construction and peculiarly fitted for those desiring to live in accordance with strict hygienic methods. It is well designed for patients requiring to follow "open-air" procedures. The Mullion Cove Hotel is situated immediately above Mullion Cove, and is quite modern. A limited number of apartments may be obtained in the adjacent village of Mullion Church Town.

Medical practitioners needing relaxation and change from the routine of the daily round of professional fatigue and anxiety may well turn to this unspoilt and altogether unsophisticated district of Cornwall's most fascinating land; and to it they may safely send many of their cases for mental rest and physical recreation.

THE total number of small-pox patients under treatment in Belvidere Hospital Glasgow, in the middle week was twenty-three.

## France.

[FROM OUR OWN CORRESPONDENT.]

Paris, August 14th, 1904.

### TREATMENT OF RENAL INSUFFICIENCY.

PROFESSOR TEISSIER, of Lyons, treating the question of opotherapy in renal insufficiency, renders testimony in a remarkable article to the value of such means in the therapeutic treatment of uræmia, and reviews the means employed to aid the weakened renal function and to replace the *role* of the suppressed internal secretion. The study of these measures is interesting not only as to the variety of their mode of action, but also as to the light thrown on the extent of the therapeutic effect and on the indications for treatment.

Teissier speaks first on the effect of the glycerine extract of the kidney employed in subcutaneous injections for the most painful complications of renal insufficiency—dyspnoea, uræmic cephalalgia, and gastrointestinal troubles. The benefits obtained from this treatment were such that frequently the patients prayed that the injections should not be suspended. It might be asked, he adds, what were the motives which retarded the diffusion of a method which, after all, was easy in application and inexpensive? The reason was, perhaps, that the treatment was only suggested when the nephritis had arrived at the ultimate phase of its evolution. Glycerine extract did not have any pretension to regenerate the parenchyma destroyed, its introduction into the economy exercised but very slight action on the glandular functions, and should not be considered as possessing a real curative effect. But by its means, the disorders caused by the toxic substances or retention can be checked temporarily, until the kidney, becoming more permeable, will allow them to filter through it.

The second means indicated by M. Teissier is the injection of a certain quantity of the serum drawn from the renal vein. The serum employed was drawn from the vein of a goat at the Veterinary School of Lyons, and employed systematically during the last four or five years.

In one case of scarlatina, the patient was taken with all the symptoms of uræmia, abundant albumin, cylindrical casts, headache, vomiting, &c.; death seemed imminent. An injection of five drachms of serum into the right flank produced a kind of resurrection the same day, and in three or four days afterwards the patient was convalescent. The casts had disappeared, and the urine reached three quarts in the twenty-four hours. Several cases cited in the thesis of Lignovolle proved the powerful effects of this treatment. The injection is well tolerated, but frequently provokes a considerable rise in the temperature. The effects are very rapid. The vomiting, dyspnoea, and headache become alleviated in a few hours in spite of the febrile reaction, while the albumin diminishes in quantity and the diuresis increases considerably, with immediate decrease of the toxins.

The third method employed to aid the functional insufficiency of the kidney consists in directly utilising the pulp of the raw kidney, as recommended by Prof. Renaud, of Lyons, and of which a full account has already appeared in THE MEDICAL PRESS AND CIRCULAR. This method, it will be remembered, consisted as follows: Two fresh pork kidneys were cut up fine and thoroughly washed so as to remove all traces of urine. They were then pounded into pulp, and a pint of cold salt water (a teaspoonful of salt) poured over them. After macerating four hours, the liquid was decanted, and the patient drank it in four or five doses in the day,

mixed with some vegetable soup (*soupe julienne*), each day for ten days, fresh kidneys being procured. This treatment certainly gave good results, but very many patients could not overcome their repugnance to it and it had to be suppressed. M. Teissier thinks that this trouble might be avoided by substituting dry preparations of the organ, presented in the very practicable form of lozenges, as prepared by certain intelligent chemists, and if the medical attendant felt some hesitation in employing them, he could always have recourse to the glycerine extract, a method much more easy in its application than injections of serum of the renal vein.

In concluding, Prof. Teissier says that renotherapy, systematically applied and continued, appears particularly indicated in patients suffering from mixed or parenchymatous nephritis. As to the preparations mentioned, the physician will choose the one best adapted to his patient. If he will bear in mind that the method is not to be regarded as absolutely curative but as an adjunct of considerable value to other means, he will experience but little difficulty in employing it. When he uræmic complications have subsided it is frequently useful to inject daily for ten or fifteen days small doses (a Pravaz syringe) of the nephrin.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 15th, 1904.

#### ELEPHANTIASIS CONGENITA.

At the meeting für Innere Medizin, Swoboda related the history of four cases of congenital elephantiasis, two of whom he exhibited.

Escherich asked if he had applied the Röntgen rays to all or any of these cases, as he had often found lymphangioma in the internal organs.

Hochsinger thought that the two cases presented to them had all the appearance of hypertrophy of the osseous structure, particularly in the lower extremities, where the tibia showed undeniable signs of exostosis, as the surface of the bone was very irregular. The Röntgen rays would be very instructive in these cases.

Swoboda replied that he had applied the Röntgen rays purposely for the bones, and found no changes in these structures.

#### PNEUMOTHORAX—RECOVERY.

Schrötter gave the history of a case of pneumothorax which had arisen in consequence of the presence in the lung of circumscribed tubercle. The patient was *æt.* 17, and had developed the morbid condition without any symptom of adhesion, although the lung was retracted at the hilus of the right side. In order to develop the lung, Schrötter practised the "biparietal" method of pressure internally and aspiration externally. He punctured the pleura and by a system of pressure bottles forced oxygen into the vesicles of the right lung, while extracting the air from the pleura, and in order to keep the lung in this distended condition he plugged the right bronchus with a firm tampon, thus holding the lung firmly distended. The tampon was attached to a fine silver catheter, which lay in the mouth and trachea, and could be withdrawn at will.

At the first sitting, when tapping the pleura, 2,200 cubic centimetres of air were extracted from the pleural cavity, which allowed the mediastinum and heart to return to their proper position, and vesicular breathing could be heard over the lung. After this the frequency of the respirations fell from thirty to sixteen per minute, and with more comfort, as the patient could now recline in sleep. Radiography showed a greater

volume of lung to the right of the middle line, though not complete. At the second sitting 500 cubic centimetres of gas were extracted, and an equal amount of oxygen injected through the catheter and tamponed as before. After this operation the Röntgen rays showed the pleural space quite filled except a small portion at the base and apex.

To accomplish the full expansion the oxygen was repeated till the full tension was acquired and all the air expelled from the pleura.

Both of the major operations were unattended by fever or any other disturbance.

#### AMÆBOID ENTERITIS.

Vollbracht showed a patient with a few preparations of amœba which he had taken from the fæces.

The patient was a waiter, *æt.* 20, and was always healthy till August, 1903, when he was suddenly attacked with severe pains in the abdomen which brought on diarrhoea that lasted three days. After this time he had two or three watery stools daily, for which he went to the local hospital about the end of the year, where he was greatly improved and left. Eight days after his return home the watery stools recommenced, accompanied with blood this time. He again returned to hospital, where he remained a month, but left having made little or no improvement.

In March, 1904, or eight months after the first appearance, he came to Vienna. According to the history elicited, the patient had never been beyond the confines of Lower Austria, nor had any similar complaint been known in his neighbourhood, borne out by local medical testimony. The microscopic examination of the stools offered nothing unusually striking in the fæcal parts, but the mucoid portion revealed a large number of pus cells as well as swollen epithelial cells, bacteria, and many amœbæ. The latter resembled in size, morphology, movement, and general behaviour those described by Loesch as amœba coli, which incorporate red blood corpuscles. Vollbracht then reviewed the history of dysentery, and thought that the labours of Schaudinn had done much to clear up the pathology of dysentery. He discovered two kinds of amœbæ, one benign and the other malignant. The former agreed with the amœba described by Loesch, which he named "Entamœba coli of Loesch," while the other, which attacked and destroyed the tissues, he termed "Entamœba histolytica."

These, according to Schaudinn's opinion, are the true pathological causes of tropical dysentery. The principal difference between these two amœbæ are that the former is fissiparous, the other gemmiparous, in reproduction. The vegetation of the histolytica has been followed on animals with the same result.

Schaudinn experimented on eight animals with the entamœba coli and failed to obtain the characteristic results of the second, although morphologically the two amœbæ are the same, though they may differ in their behaviour through the different functions of the nucleus and ectoplasm.

When the same experiments were carried out with the entamœba histolytica the characteristic action was immediately apparent within a few hours. The amœba rapidly increased, the mucoid tissue was quickly destroyed, and the life of the animal sacrificed within a very short space of time by the ravages of the protozoon.

#### CONGENITAL MUSCULAR DEFECTS.

Neumann, as well as Vollbracht, exhibited a few cases of congenital malformation in the muscular apparatus. One of Neumann's cases had complete absence of the right pectoralis major, minor, and

partial defect of the left, besides a very rudimentary 'formation' of the ancillaris. In spite of these defects the patient was able to carry on work as a washer, and moved the right arm with as much freedom as his left. The strength of the one arm was as powerful as the other when tested with the machine, as the development of the brachial muscles testified. The adduction of the right arm was very little less than the left. Notwithstanding this functional activity he obtained military exemption.

The etiology was congenital, but no defect of any kind is to be traced in the family history. The mother testifies to the flat side of the chest after birth.

Völlbracht had a similar case to this with the absence of the serratus major in addition, who could perform ordinary labouring work.

## Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, August 13th, 1904.

It is always an event in the Hungarian medical world when a new work is published, which is not to be wondered at, considering the fact that most of the Hungarian doctors only speak German, and, consequently, read the much cheaper German medical books. Lately, three new works have been published in Budapest: the first one is the "Clinical Pharmacopœia," edited by Dr. Miller Vilmos, whose name is as well known in Hungary as in Austria, since he initiated the inoculations against tuberculosis with the Marmorek serum. His book comprises the prescriptions of the Budapest clinics. Instead of writing praises about the book, I shall quote a few prescriptions of standard value:—

Prof. Korányi prescribes for appendicitis opium suppositories, a liquid diet, rest, ice-cold lemonade, champagne. After cessation of the acute symptoms, the diet may again be as before. For the promotion of resorption, Preissnitz fomentation, brushing with tincture of iodine, or with the following mixture:—B. Icthyol sulfammon., 5.00 grs.; collodii flexilus, 15.00 grs.

In cholelithiasis Prof. Korányi prescribes, besides a Carlsbad cure, the following formula:—B. Ennatsol (oleic acid soda), 10.0 grs.; tinct. valerian. æth., 5.00 grs.; aq. menth. pip., 180.0 grs.; essent. ananas, 2.00 grs. M.; four tablespoonfuls to be taken daily.

The book has interesting chapters also on pediatrics, gynecology, surgery and the other main branches of medicine. The preface is written by Prof. Korányi.

Hr. Doktor Sándor has revised the obstetrical manual of the late Prof. Kermárski Tivadar, whom he greatly respected as his teacher and loved as a friend. Kermárski's book is well known both in Hungary and Austria, but Kermárski himself is well known beyond these two countries. His clinic embraced and welcomed many foreigners because, having been built up in 1901, it is one of the handsomest institutions of the world, built and arranged after the best clinics on both sides of the Atlantic. The book is considered an able work, many parts of it having been re-written by Dr. Sándor, whose pen and knowledge have been put at the service of even non-medical papers.

Every page of the book, besides showing the strictest science, is a proof of the grand estimation he has for his principal. The book is adorned with Kermárski's photograph, and two pages are devoted to the biography of Kermárski. He was for thirty years the teacher of obstetrics. He learned his art in

Budapest, Berlin, Paris and London. Among his foreign teachers he was fondest of Spencer Wells and Baker Brown, and the impressions which he brought back from England left traces on his whole working and function.

Hr. Doktor Sándor has done really a very appreciable work in undertaking the republication of this renowned work.

The third work which I desire to report is Dr. Rona Sámuel's work on sexual diseases. Prof. Rona is also well known beyond Hungary, for he has been constantly present at Congresses held, not only on sexual diseases, but also on other branches of medical science. His book is full of practical information based on a very large hospital practice, so that his cases outnumber those of any Vienna clinic. Prof. Rona begins his work with an historical review of syphilology, upon which he has bestowed very careful attention. A special feature of his book is the novel method of dealing with the subject from a sociological point of view. In every chapter allusions are made to internal and constitutional diseases which may be associated or accompanied by venereal diseases.

It is really a pity that our able works can be read only by a few million people, as the Hungarian language can be read by only ten millions.

## The Operating Theatres.

### NORTH-WEST LONDON HOSPITAL.

AMPUTATION AT THE HIP-JOINT FOR SARCOMA OF THE FEMUR.—Mr. THOMSON WALKER operated on a woman, æt. 27, who had been admitted for a swelling of the right knee. Fourteen months before admission the right knee was noticed to be enlarged. There was no history of injury, and she had not suffered from rheumatic or other joint disease. The family history was unimportant. The knee continued to enlarge very slowly, in spite of local rest and counter-irritation. It was painless; there was no tenderness on palpation or movement. Two months before Mr. Thomson Walker saw her, she went to the seaside, and the knee began rapidly to increase in size. Dr. Moorhead, of Bridge, then asked Mr. Walker to examine the patient with a view to operation. On admission to the hospital the following condition was found: The patient was healthy-looking and well-nourished, there was a large swelling of the right knee, which consisted of a rounded prominence on the inner side and an obliteration of the outlines on the front and outer side. Only a slight degree of flexion was possible. The patella could be felt on the front of the mass and was movable. The skin was unchanged. The mass was firm and in places hard, and careful palpation showed that it was connected with the lower end of the femur, the upper end of the tibia being apparently unaffected. Although parts of the enlargement were of almost bony hardness, no egg-shell crackling could be felt. Fluctuation was not detected, and there was no tenderness on palpation. The lymphatic glands in the groin were not palpable. A diagnosis of periosteal sarcoma of the lower end of the femur was made, the points considered important in diagnosis being: the size and asymmetry of the swelling, the varying consistency of the growth, and the extreme hardness of parts of its surface, and its connection with the femur. The absence of aching or pain and of egg-shell crackling, the rapid growth, and the peculiar outline were the points in favour of periosteal as compared with endosteal sarcoma. An X-ray photograph showed the shadow of a large rounded mass connected with the inner condyle of the femur

the circumference of this shadow showed an appearance like spicules of bone radiating from the centre. Amputation at the hip-joint was performed. The method used was that known as the anterior racquet incision. The femoral vessels were first exposed by a vertical incision commencing over Poupert's ligament. The artery was first ligatured in two places, and subsequently the vein; these vessels were then cut across; some venous bleeding, owing to a high junction of the deep femoral vein, gave a little trouble. The incision was then carried across the inside of the thigh, four inches below the genito-crural fold, then round the back of the thigh and passed round the outer side, three inches below the upper border of the great trochanter. No further bleeding of importance occurred. There was a little difficulty in the actual disarticulation of the head of the femur, but by freeing the great trochanter and by external rotation and flexion of the limb this difficulty was overcome. A drain was inserted reaching to the acetabulum and protruding from the lower end of the antero-posterior wound. The principal feature of this amputation, Mr. Walker said, was the control of the hæmorrhage by ligation of the main vessels at the commencement of the operation; this, he pointed out, dispenses with the use of a tourniquet, which is difficult to keep in position in this situation. The operation of Furneaux Jordan's, he said, was that usually recommended at the present time, but the operation he (Mr. Walker) had just performed appeared to him to have many advantages in a case such as the present one, especially with regard to the control of hæmorrhage. Furneaux Jordan's method of amputating through the thigh low down and then shelling out the femur, he pointed out, is that usually recommended at the present time for disarticulation at the hip-joint. The grounds on which this preference is based are the slighter degree of shock and easy control of the hæmorrhage, the position of the drainage-tube on the outer side away from the genitals and anus, and the longer and more mobile stump. The amount of shock in the case Mr. Walker had just operated on was not great, and he doubted if it would have been less by the Furneaux Jordan method. The easy control of hæmorrhage he thought the special feature of the anterior racquet method. The preliminary ligation of the femoral vessels relieves the mind of the surgeon at once of any anxiety in regard to hæmorrhage, and permits of rapid completion of the operation. The sciatic artery is very small at the point at which it is severed, and the gluteal vessels are not disturbed. The lower angle of the antero-posterior wound, he considered, was an ideal position for drainage, and this is not so near the anus that ordinary care cannot prevent soiling of the wound. There was no advantage in his mind in having a longer stump if it carries no bone. If an artificial limb can be fitted at all it will, he thought, be as useful on the stump of an anterior racquet amputation as on that of a Furneaux Jordan's. The former method, therefore, appeared to him to be preferable in cases like this when the hip-joint is not diseased. The prognosis in a case such as this was somewhat doubtful. Some slightly enlarged glands were found in the groin during the amputation, but under the microscope they contained no tumour cells. Microscopic examination of the tumour showed a few giant-cells, and these are usually considered to represent the slower-growing and less malignant endosteal sarcoma. It is not, however, certain, he said, that the presence of these cells is distinctive, and the absence of expansion of the bone and the other characteristics led him to believe that the original diagnosis of periosteal sarcoma was correct. The prognosis in this case was

therefore less hopeful. After the operation the patient showed signs of collapse, and a pint and a half of saline solution was infused into the left median basilic vein. It was not, however, necessary to repeat the infusion, and the convalescence was uninterrupted. The drainage-tube was gradually shortened and finally removed on the eighteenth day. The temperature rose to 101°, and continued at this level for a week. It then fell and remained normal.

Six weeks after the operation the stump was firm and could be tilted forward by the patient. The scar had contracted lengthwise and lay in the anterior surface of the stump.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, AUGUST 17, 1904.

### MEDICAL MEN AND LITERARY COMPOSITION.

THE literary acquirements of medical men, as a broad and general rule, are notoriously wanting in the essentials of good craftsmanship. As with their handwriting, good matter is spoiled and unreadable because of the defective methods of expression. In this way many a skilful surgeon and many a learned physician fail when they endeavour, pen in hand, to convey to others the knowledge gathered from wide reading and long experience. On the other hand, not a few of the names that have become household words in the history of the profession owe their pre-eminence in no small degree to the possession of a sound literary style. Yet the elementary principles of English composition are easy of acquisition, and, so far as that goes, should be included in the scope of every liberal education. The fact of the matter appears to be that medical men are so engrossed in the practice of an exacting profession that they have little leisure or inclination for the art of letters. For all that, the busy practitioner will find both relaxation and profit in the study of English composition. He will find an admirable essay on the subject, compact with valuable information, in a little book recently published by Professor Clifford Allbutt under the title,



"Notes on the Composition of Scientific Papers." In the course of each year the author is called upon to peruse some sixty or seventy theses for the degree of M.B., and about twenty-five for that of M.D. "The matter of these theses is often excellent, but their prevailing defect is such as to obscure, to perplex, and even to hide or travesty the sense itself. Meritorious in substance as these productions may be, they are, as they stand, unfit for the printer." This picture will be recognised by editors of medical journals as representing the attitude of the average contributors. It is not merely such disfigurements as the split infinitive and the misplaced "only" that offend his eye, but also the frequent occurrence of errors of grammar and of offences against the elementary rules of composition. The misuse of relative pronouns is a fruitful cause of confusion. Dr. Allbutt's illustration from a recent thesis runs thus:—"He said to his patient that if he did not feel better, he thought he had better return to say how he was." The ambiguities remind us of the well-known examples, "No one had yet demonstrated the structure of the human kidneys, Vesalius having examined them only in dogs." The author's rule in this particular case is admirable: "On the revision of a manuscript, pause at every such pronoun till you are sure that its particular antecedent is unmistakable." False concords are plentiful as blackberries in ordinary medical manuscript, as, for instance, "The shame and pain to which his failure expose him"; "Nothing but his poverty, modesty and diffidence prevent"; "Neither of these boys were remarkable"; "Of these persons none (no one) were robust." An amusing error, often committed even by good writers, is that of the intrusive "not." The complete logical subversion of meaning that may be thereby caused is shown in the following sentences: "I ran to see if I could (not) get a seat"; "Let us see if we can (not) help him"; "I cannot say what disease she may (not) have"; "Mr. Jones asked if both lungs might (not) be diseased." An extremely common inelegance among unpractised writers is the use of short suspensions within larger periods: "To improve, as much as possible, the general health, &c.," would read better by changing the position of the two clauses. "He made many sketches of, and gave close attention to, the village churches of the county" diverts the emphasis to the unimportant words "of" and "to." A more correct and logical rendering would be, "He paid close attention to the churches, and made many sketches of them." Neglect of the proper order of words leads to numberless comical effects, as: "They followed the party step by step through telescopes"; "Ford's theatre is for sale where Lincoln was assassinated for religious purposes"; "A clever magistrate would see whether he was lying a great deal better than a stupid jury"; "I understand that when he died Cardinal Mezzofanti spoke at least fifty languages." This book of Dr. Allbutt's is stuffed from cover to cover with information of interest and of

practical importance to all members of the medical profession who wish to reduce their thoughts, wishes, aspirations or experiences to literary form.

#### HOLIDAY EXERCISE.

At this season of the year, when every town-dweller to whom the opportunity presents itself makes for the country or the sea-side, the question of appropriate exercise becomes an eminently practical one. A holiday has been defined by advocates of the "strenuous" life as a change of occupation, and to the average man, so long as the change involves an abandonment of brain fatigue, and a substitution of physical for mental exercise, the medical man will not be inclined to quarrel with the definition. It may, however, be well to protest against the attitude of mind of those who consider a holiday wasted unless its precious hours are filled by the pursuit of fresh knowledge and experience. A symposium of opinions of some leading Members of Parliament recently taken by one of the leading morning papers contained the views of several representatives of manufacturing towns, who held that the ideal holiday of a young Londoner was to be found in a visit to some Yorkshire or Lancashire town to study the processes of manufactures carried on there. With all respect for the legitimate desire of men to improve themselves on every suitable occasion, we cannot but think that for a young clerk or business man to spend his short fortnight or three weeks' vacation in an atmosphere of looms and machinery is to court disaster. To all mentally hard-worked men the holiday should be emphatically a period when the mind lies fallow, and when the body is given the chance that it so rarely gets of moderate, healthy exercise. It is obviously foolish for the man whose muscles are flabby and whose circulating and respiratory mechanism is out of tone to attempt herculean feats as soon as the black coat is changed for flannels, and much damage is often inflicted on themselves by enthusiasts who try by means of sudden and violent exertion to get as much "good" as possible out of their holiday. All violent exercise must be preceded by a period of training if the strain is to benefit the system, and for the average vacation the gentle cult of *dolce far niente* is infinitely preferable to fatiguing bicycle rides or exhausting expeditions that tax the powers of endurance of their subjects to the uttermost. Some interesting observations recently made by Dr. Philip Hawk, Demonstrator of Physiological Chemistry in the University of Pennsylvania, tend to show the comparative value of various forms of bodily exercise, and in them the physician may find a scientific basis for advice he may be called upon to give as to the best holiday pursuit for his patients. The method adopted by Dr. Hawk was to examine the blood of athletes before and after exercise, making counts of the red corpuscles with the hæmocyto-meter. His observations showed that the blood of the average college athlete in good training contained

over a million more red cells than that of the average individual, namely, 5,600,000 corpuscles per cubic millimetre, as compared with four and a half or five million. Such an observation is of great value, as it demonstrates the fact that the properly-prepared athlete differs structurally from the untrained man, and that he may therefore be assumed to be capable of deeds that would be beyond the powers of the latter. An ordinary individual, then, whatever his potentialities, should regard himself as being incompetent to undertake feats of endurance or strain without thorough preparation as he would be, say, to appear for his county at cricket without weeks of careful practice at the nets. Dr. Hawk found that the immediate effect of exercise was to increase rapidly the number of red corpuscles in the blood, but that this increase readily fell as the exertion was continued beyond a certain point. He attributes this to the necessity of calling into play numbers of cells that have been accumulating or lying in reserve during periods of inimitable action, and to the rapid depletion of this supply when the demand is sustained. So far his observations are not complete, for he is endeavouring to find out what is the effect on the blood when exertion is continued to extreme degrees, but his results as to the comparative increase of corpuscles under various forms of athletics are suggestive. Thus he found the percentage of gain after a hundred yards' sprint to be 24·8 of the total number of corpuscles, whilst the hundred and twenty yards hurdle race produced a 21·5 increase; the half mile, 17·9; the mile, 13·9; two miles, 8·8; broad jump (after six jumps), 15; three minute water polo game, 27. Here it will be seen that while the short, sharp strains produced a sudden high increase, the more leisurely and longer-continued exertions showed distinctly smaller gains, and examinations on bicyclists and pedestrians confirmed these results, the initial increase rapidly diminishing as the exertion progressed till it disappeared altogether. Reviewing his observations, Dr. Hawk concluded that swimming is the ideal sport. This form of muscular exercise was found to produce an average increase of 21 per cent., as compared with an increase of 16·5 per cent. after sprinting, 12·8 per cent. after walking, and of 12 per cent. attained as the result of bicycling. Short swims, averaging three minutes in duration, produced an increase of 22·5, as compared with 13·9 per cent. found after swims of a quarter of an hour's average duration, during which period the subject was putting out as large a share of activity as possible. This method of Dr. Hawk's for examining the effect of exercise on the organism would seem to be a valuable one, and it certainly teaches the lesson of the unwisdom of persisting in an exercise that is making too great demands on the reserve of corpuscles. We hope he will continue his observations and that these may embrace some tests of athletes, such as Holbein and Weidmann, before and after some of their prodigious efforts. To the plain man, however, the conclusion

is clear, that the holiday should be a time for accumulating a higher percentage of corpuscles and that arduous and fatiguing exercises, far from doing this, will only destroy any reserve that he may be already possessed of.

#### THE TREATMENT OF ACCIDENTAL HÆMORRHAGE.

SIR ARTHUR MACAN'S valuable paper, read before the recent meeting of the British Medical Association, on the subject of accidental hæmorrhage during pregnancy, and the discussion to which it led, may be said to point a moral and adorn a tale that will not perhaps be useless to the coming generations of English obstetricians. The tale is very similar to that related to the Obstetrical Society of London by Dr. Teacher, in his now classical paper on "Deciduoma Malignum," and its burden is that preconceived and settled ideas, when not supported by facts, hinder progress. The moral is, if we may express ourselves in the vulgar fashion, to beware of "cock-sureness." Past students of the London medical schools will remember how a well-known London writer on obstetrical subjects openly stated that he would "plough" any student who told him that in cases of accidental hæmorrhage he would plug the vagina. Many of the same students came to Dublin to learn their midwifery in the Dublin maternity hospitals. They saw there the treatment, which London had condemned, adopted with the result that the mortality of accidental hæmorrhage, instead of being 40 to 60 per cent., as they had been taught, was something between 3 and 8 per cent., and they were confessedly puzzled. The question immediately occurred to them—why should Professor So-and-So in London state that the mortality of accidental hæmorrhage was 40 per cent., and that plugging would kill the patient, when in Dublin the mortality is inappreciable, and the vagina is always plugged? This condition of affairs was the rule ten years and more ago, and yet it is but within the last year or two that the London obstetrical school has come to recognise that dogmatism and truth do not always go together. The London Obstetrical Society laid down that the tumour known as deciduoma malignum was nothing but a sarcoma of the uterus. As a result, the majority of English obstetricians and pathologists took no further interest in the growth. Everything was known about it, the Obstetrical Society had told them so. However, it was subsequently found that the Obstetrical Society had told them wrong. Similarly, with regard to the treatment of accidental hæmorrhage, London opinion laid down three "laws": that the student who suggested the plugging of the vagina would be "ploughed"; that the medical practitioner who used the plug would kill his patient; and that the plug would convert an external into an internal hæmorrhage. The two last "laws" were proved to be wrong, but still the first remained, and as a result the spread of the knowledge of the treat-

ment was delayed, and many lives were sacrificed. At last a change came. The younger generation of obstetricians decided to think for themselves, and to cast off the hereditary shackles by which they had been bound. The Obstetrical Section of the British Medical Association agreed to discuss the treatment of accidental hæmorrhage. The chief active opponent of the treatment by plugging remained away from the discussion; the chief passive opponent confessed that he had always thought well of the treatment, but out of regard for the examination prospects of his students he had refrained from mentioning it; and Sir Arthur Macan's paper was heartily accepted by the meeting. We trust that as a result of the change of opinion the pendulum will not now swing too far in the opposite direction, and cases be treated by plugging for which such a treatment is unsuitable, and so discredit be brought on the method. Plugging the vagina is the best treatment that has as yet been suggested for cases of accidental hæmorrhage in which the patient is not in labour and in which the bleeding is external. It is a useless line of treatment in cases of severe concealed accidental hæmorrhage, unless the uterine wall has commenced to react against a further increase in the uterine contents. It is an unnecessary line of treatment in cases in which the patient is in advanced labour and the uterine contractions are strong. As the present appears to be a favourable time for the upsetting of preconceived ideas, we would venture to suggest that the supremacy of Marion Sims' position in gynecological examinations and operations should be attacked. We think that we are right in saying that England is the only country which still adheres to this position, and that the use of the more generally adopted dorsal position does not favour the occurrence of parametritis, as was recently stated by an English writer.

### Notes on Current Topics.

#### The Administration of the R.A.M.C.

A RECENT writer in the *Westminster Review* has made a discovery which is so good that we desire to reproduce it in his own words:—"The latent talent for administration possessed by the Anglo-Saxon is neutralised in the R.A.M.C. by the Irish and Scotch members who form the bulk of its members. The racial and national peculiarities of these two preclude them from being successful administrators. The excessive vanity of the one and the inordinate conceit of the other are quite antagonistic to that calm discussion, gentle spirit of compromise, and firm perseverance which render pure Englishmen of any rank and any degree of education such wonderfully successful and able administrators and organisers." It seems to us that nothing but a combination of "excessive vanity" and "inordinate conceit" could make anyone so willing to display his ignorance of the nationality of, we think we may say, the majority of the great administrators of the Empire. We would suggest to this "pure Englishman" that his

sentiments should in future be couched in pure English, and that they should be influenced, if not altogether guided, by the dictates of common sense and—truth. Perhaps, however, he is what the Scots call a "puir body."

#### A Post-Dated Medical Certificate.

IT is difficult to imagine any set of circumstances under which the post-dating of a medical certificate could conceivably be prudent and altogether defensible. Certainly not when the document was drawn up to excuse the attendance of a juror at a trial to be held nine days after the date of signature. Yet that is the kind of certificate recently presented to Mr. Commissioner Lawrence, K.C., at Liverpool Assizes. The judge stated it had come to his knowledge that a certificate had been handed in from a Liverpool practitioner to the effect that a certain juror was unable to attend, and post-dated by thirteen days. The reason that had been offered for adopting that course was the fact that the doctor was going out of town, and that his professional skill enabled him to say that the juror would not be able to attend. That was, to the judge's mind, a mode of dealing with the matter that was highly reprehensible, and was a view of the duties of the medical profession which he could not congratulate the gentleman upon entertaining. Judges, he remarked, had been in the habit of treating medical gentlemen as gentlemen who could be implicitly relied upon, and any departure from that course on the part of a member of the profession was not only calculated to injure the profession, but was also a serious offence against the State. We agree that any medical man acts foolishly who tampers with certificates. At the same time, it would be better were the legislature, which expects so much, to pay medical men for certificates on a scale commensurate with the fees enjoyed by the legal profession.

#### Self-Certified Lunatics.

THE judicial view of what constitutes attenuated responsibility in criminals suspected of mental aberration is in startling conflict with that of medico-legists and psychological experts. The judge's directions to a jury in a recent case of murder by an otherwise well-conducted but hereditarily damnable youth, emphasise this divergence of opinion to such a degree that it becomes a *reductio ad absurdum*. He warned the jury against accepting the theory of "uncontrollable impulse," of which, he added, medical men were very fond, and he laid it down that every person was assumed to be sane until the contrary was proved, and that it lay with the prisoner to establish this. But how is a prisoner to prove this except by acting as a lunatic? When a wealthy person indulges in petty theft it is mercifully described as kleptomania, and probably in most instances with due reason. When a previously well-conducted youth commits murder without adequate motive surely he has done all that could reasonably be expected of him to establish his unsoundness of mind. We must confess that we are

unable to understand the dogged resistance of the judicial mind to the medical theory of attenuated responsibility. In murder cases, at any rate, there is no risk of the accused being let loose on society to perpetrate further acts of violence; it is merely a question whether he should be "treated" in prison or in an asylum. Surely the medical man is the best judge of cases suitable for admission to hospital. The fact is, that in presence of purposeless acts, especially if corroborated by a neurotic family history, the assumption ought to be exactly in the opposite direction. It is satisfactory to find that in this particular instance the jury were not led away by the judge's sophisms, and found that the prisoner was insane.

#### Suture of an Artery.

IN the "Annals of Surgery" for July is recorded a remarkable case of suture of the brachial artery, which was so successful that it merits wide publicity. The patient was a boy of seventeen years of age whose upper arm was severely lacerated by a crush from the wheel of a car. The muscular structures of the outer side were torn in various directions and the humerus was exposed to view. The wound was treated in the usual way, but towards the end of the week profuse hæmorrhage supervened. The radial pulse could not be felt, and the whole arm below the wound was cold, dark, and œdematous. Gaston Torrance, under whose care the case was admitted, opened up the wound and found a funnel-shaped ulcer about the size of the point of a pencil in the wall of the brachial artery. At each beat of the heart arterial blood was shot through the aperture, and the patient's condition was one of some anxiety. Torrance attempted to close the opening by suture, but his first attempt made with the arm extended was futile, as the stitch tore out when it was tightened, and the hæmorrhage proceeded with unabated force. He then tried to relieve the tension on the stitch by bending the arm, and the relaxation being secured, he inserted a purse-string suture around the margin of the ulcer with a fine curved intestinal needle. When the suture was drawn together it was found that the bleeding was completely controlled. In order to give added security, a piece of muscle was dissected up and grafted over the anterior portion of the artery. In four hours the pulse-beat was easily perceptible in the radial, and after two weeks in bed and two months subsequent use of a splint, the boy went home with a thoroughly useful limb. Suture of a large artery in its continuity is seldom called for, but this case illustrates particularly well the hopefulness of the method when applied with skill and intelligence.

#### An International Medical Language.

IN these days of international congresses and free exchange of scientific ideas the need for a common language of intercommunication is badly felt. Many praiseworthy and ingenious attempts, from Volapuk downwards, have been made to establish a universal language, but no sooner is a good

tongue invented than along comes another with still greater claims to attention. People consequently become bewildered, and awaiting universal approbation nothing is done. From the point of view of medicine a *lingua franca* is undoubtedly a great *desideratum*. Science has no home and no country, and with the ever-increasing volume of observation and experiment carried on in every land the medical man becomes more and more unable to keep as well abreast of current knowledge as he would wish to do. It seems a thousand pities that Latin has fallen from its place as the recognised medium for medical writings, for not only is Latin the basis of most of the occidental languages, but it is one peculiarly well adapted to the purposes of science. One cannot help noting it as a curious fact that coincidentally with the widening of education and the consequently great diffusion of classical knowledge, Latin has gradually become less and less familiar to the physician of culture. It is doubtful if at this moment 10 per cent. of the Fellows of the College of Physicians could read or write a medical paper with anything approaching facility in the Latin language, and it is quite certain that not 1 per cent. of readers of a medical journal would attempt to decipher it. A hobby of one of our contemporaries is to push the claims of modern Greek as the language for general medical purposes, but, in all sympathy, we fear that their dream will not be realised in our generation. The solution would seem to be a natural one, namely, the adoption by other nations of the language of the race which attains the greatest pre-eminence in the political and scientific world, and we incline to believe that English will eventually prove to be that language. At any rate, it is not likely to be Japanese for another century or two.

#### The Digestibility of White Bread.

IT is not always the medical and scientific journals which single out the various articles of food in turn for the purposes of "attacking" them, as the lay mind loves to think. That they expose adulteration and fraud everybody will recognise, and in this capacity they render valuable aid to the community at large by calling attention to the composition or quality of the different food-stuffs and to the risks of possible contamination which the consumers run when the laws of hygiene are infringed. A certain section of the daily press is apparently fond of adopting the same policy, presumably because it is found that the public are pleased by the admission of medical or rather pseudo-medical details into the columns of their morning paper. A correspondent of the *Times* has recently stated that the present craze for white bread constitutes a danger to the public health. If it be true that the alleged practice of bleaching the flour by means of ozone and nitrous acid, which is said to be adopted by many bakers, is really universal, it might be conceived that the bread baked from such flour might have injurious effects, unless special precautions be taken. All

white bread, however, is not necessarily an "indigestible, non-nutritive food," though the presence of mineral matter or an excess of starch renders it unfit for those possessed of delicate stomachs. The inclusion in the flour of the central portion of the wheat-kernel is generally held to be incompatible with snowy whiteness, but there can be neither rhyme nor reason for sacrificing the phosphates and other nutritive principles merely for the sake of appearance. Many patent breads now on the market, including the aerated variety, are praiseworthy and successful attempts to preserve the nutritive properties of the flour, while combining it with a pleasing appearance. The connection between the consumption of white bread and the prevalence of appendicitis need only be mentioned to be denied *in toto*.

#### Examination of Sputa in Children.

WHATEVER may be the faults and drawbacks of young children, there is one nuisance which they are never guilty of—that is, the spitting nuisance. However fortunate it may be for their fellow-creatures that they do not spread their maladies by expectoration, their medical attendants are sometimes considerably handicapped in making their diagnosis by being unable to obtain specimens of sputum for examination. In suspected cases of early tuberculosis the staining of the sputum is of paramount importance, and delay in the resolution of pneumonias, or the development of some located empyemata, often make the practitioner anxious to check the diagnosis by appeal to the sputum. Several plans have been devised from time to time to obtain expectoration for examination, notably that used by Hirt of passing a stomach tube and collecting the mucus that adheres to it. A simple and satisfactory method has been put forward by Findlay, who learned it from the French hospitals. This consists in covering the finger with gauze and passing it into the aperture of the glottis. The irritation thus excited induces cough, and as the mucus is ejected it is caught on the gauze and reserved for examination. The device is so simple and, withal, so efficacious, that it will be welcomed as a boon by many practitioners.

#### Kyphosis of Muscular Origin.

THE influence of osseous changes in the production of deformities, especially those in which the spinal column is involved, so far outweighs that exerted by other tissues of the body that the possibility of a given malposition being due to causes other than bony is apt to be overlooked. The contractions which appear as a result of paralysis of the limbs are quite familiar, such deformities having their origin in muscular contraction induced by chronic irritation of a nerve-cell or nerve-trunk. Most of the deformities affecting the spine arise from actual changes in the bodies of the vertebræ themselves. With the exception of lateral curvature, alterations of the normal antero-posterior curves of the spinal column are generally due to absorption of the vertebral

bodies from the deposit therein of tuberculous material. The case related by MM. Brissaud and Grenet (a) of kyphosis due entirely to muscular action is, therefore, of some interest. The patient was a man, aged thirty-seven, who had suffered for three years from severe pains in the back, ascribed to rheumatism. He had a regular kyphosis which was less on rising in the morning. The arms were held in semi-flexion. There was no joint-affection, and the vertebræ appeared to be quite normal. The reaction of the spinal muscles to faradism was not diminished, neither was there any reaction of degeneration. The condition was greatly improved by the continuous application of a Sayre's jacket. The observers considered that the case was allied to the condition described by Forestier as "vertebral rheumatism," or rheumatic spondylosis. Similar kyphotic states have also been seen as the result of occupation, as, for example, in vine-dressers. The long-drawn-out antero-posterior curve which occurs as a special type in the aged is sometimes the partial effect of muscular shortening.

#### Inflation in Acute Intussusception.

THE treatment of acute intussusception in young infants still constitutes one of the critical problems of surgery. In spite of the most approved methods of treatment the mortality from this affection remains almost what it was twenty years ago. The best possible chance of recovery appears to be afforded by the immediate performance of laparotomy and actual manual reduction of the bowel. This procedure requires some considerable force, so that the bowel stands in some danger of being torn across. A slight tear, involving only the muscular and peritoneal coats, is not of much importance, as peritonitis is said not to occur under such conditions, but should the mucous coat be lacerated and the lumen of the gut exposed, the matter is far more serious. Rapid resection, if possible, is then the best course to pursue. The other method, that of inflation, whether with fluid or air, is the one still adopted by the majority of practitioners, for it has the advantage of being a less formidable undertaking than abdominal section. Mr. F. J. Steward, (b) of Guy's Hospital, has collected several groups of cases together, showing the results of inflation, and he concludes that this mode of treatment must be regarded as a failure. In the first place, it is unsafe to employ the amount of force which is necessary to reduce the intussusception on account of the danger of rupture of the bowel. If the condition extends higher than the ileo-cæcal valve, inflation must fail, because it has been proved experimentally that the injection of water or gas cannot pass beyond this point. Complete reduction may only apparently take place, which again is a most undesirable occurrence. The greatest drawback of all, perhaps, is that the effects of inflation are invisible, and, therefore, the method is both unscientific and uncertain.

(a) *Nouv. Icon. de la Salpêtrière*, No 2, 1904.  
(b) *Guy's Hospital Gazette*, July 30th, 1904.

The earlier laparotomy be performed in these cases, the more chance will there be of ultimate success.

#### An Alleged Unauthorised Post-Mortem.

It is obviously inadvisable to make a post mortem examination on the body of a patient without having obtained the consent of the friends of the deceased or an order from the coroner. In both cases to act without authority is to invite consequences of a most unpleasant nature. Mr. John Shaw Carleton, a surgeon practising at Newnham, Gloucestershire, has had to appear before the Littledean Petty Session, because he conducted a post-mortem on a body without consent of friends, and in the absence of a direct written direction from the coroner. It appears that he regarded as sufficient authority a letter from the Deputy Coroner directing him to examine the body if requisite, and if an inquest were held. Unfortunately for him an inquest was not considered requisite. The magistrates dismissed the summons, as they did not think on the evidence that a jury would convict. The charge was drawn up in a formidable manner under the Anatomy Act. There were three summonses as under: (1) That he, upon July 25th, being a person lawfully qualified to practise medicine, unlawfully did practise anatomy without having obtained a licence in pursuance of 2 and 3 William IV. c. 75, empowering him to do so. (2) That on the same date, being qualified to practise medicine, unlawfully did examine anatomically the body of John Price without the permission or the direction of the surviving wife. (3) That he did unlawfully carry on anatomy at a place, to wit, the house of Emily Price, there situate, without having given at least one week's notice thereof before the first receipt or possession of the body for such purposes to His Majesty's Secretary of State for the Home Department.

#### Headache Powders.

WITH the medical paragraphs of the ordinary lay newspaper it is impossible to feel the least sympathy. As a rule, they form a sort of compost of sensationalism, of mis-statement, and of false science, dished up by a journalist absolutely ignorant of medicine but wotting well the wants of his public. As a rule the evil done by these slipshod efforts to popularise one of the most highly technical of all sciences is simply incalculable. The only other thing with which it is at all comparable is the crop of disaster sown far and wide by quack advertisements. In that particular, again, with modern lay journalism lies the head and front of the offending. Who can even faintly estimate the total sum of human suffering and sorrow caused by the fraudulent enterprises of curers of kidney disease, of cancer and of a host of other more or less deadly maladies? Curiously enough, the average mind seems always to have a corner open for the quack, even among folk of culture and of position in society. The only item

on the other side of the ledger with which we can credit modern journalism is an occasional crusade against "headache powders" and drug-taking generally. Even such exposures are conducted in a way that must necessarily furnish a great and unnecessary amount of dangerous detailed information to weak-minded readers.

#### An Unpleasant Experience.

THE ways of British administrative law are at times apt to press heavily on the individual, however much there may be to admire in them as a whole. That they are capable of improvement is a more or less self-evident proposition. That view, at any rate, is likely to be held positively by Mr. A. B. Avarne, a Blaenavon surgeon, who recently had a most unpleasant experience of administrative red-tapeism in Cardiff. It appears that his luggage was stolen at the railway station of that town, through which he was passing on his way to a holiday on the Continent. The thief was caught, brought up at the police court next morning, and charged with the offence, and remanded for a week. The whole of Mr. Avarne's kit was contained in the stolen luggage, which the Court took into custody. His very reasonable request that he should be allowed to use some of his clothes was refused by the Bench. This weak point in the administrative law is clearly due to the remand system. If the prisoner had been summarily sentenced or committed for trial, as should have been done, the stolen property could have been restored forthwith to its owner. The remand was doubtless due to the gross injustice of the British law, which seeks to punish a culprit afresh for former offences, and, with that end in view, remands him again and again so that the police may trace his former career.

#### Light Treatment of Small-Pox.

WITH every desire to be fair and to preserve an open mind with regard to new therapeutical methods, it is often difficult to credit the statements that come from even highly reputable quarters as to the efficiency of this, that, or other treatment. A certain healthy scepticism with regard to medical novelties is by no means to be deprecated, and in the interests of the patient who is likely to form the *corpus vile* of the experiment, it is even to be welcomed. The red light treatment of small-pox has been reported on several times from Scandinavian sources, always in glowing terms, and although it is really a resuscitation of one of the crudities of the Middle Ages, the fact that this plan is based on empirism is no valid argument against its adoption if really beneficial to patients. As the treatment of sufferers in what is practically a "dark room" can, at the worst, have but little effect on their comfort and well-being, it is satisfactory to know this method has been thoroughly tried over here. Dr. Ricketts, the Medical Superintendent of Joyce Green Small-Pox Hospital, decided to test its efficiency, and his



experience, published in the Annual Report of the Metropolitan Asylums Board, should settle the matter once and for all. A small ward was set apart for the purpose, the windows being covered with ruby fabric and the ward doors hung with thick curtains of Turkey twill. Illumination was supplied by a red lamp. In this room one or two patients were placed at a time, all of whom were subject to careful selection. Those chosen were in the early papular stage of attacks that seemed likely to run an ordinary suppurative course. In all some twelve cases were treated, in none of which was the development of the stages of the papules in any way different from what might have been naturally expected. Three patients died and several were badly pitted. Dr. Ricketts' reputation for scientific insight and care is a sufficient guarantee that the treatment was accurately and conscientiously carried out, and it may be unhesitatingly pronounced a dead failure. We are glad that the little experiment has been made, as the question may now be relegated to the region of *choses jugées*, and we are left to wonder how such an unlikely wild-cat plan came to gain such a reputation. We can only surmise that what our Scandinavian friends need for the treatment of small-pox is not the light of a ruby globe, but the light of common sense. For the future the doctor's red lamp will be of more service outside his front door than inside the bed-rooms of his small-pox patients.

#### The Medical Profession in Germany.

THE condition of the medical profession in Germany can be gauged by a warning to those thinking of entering the profession recently issued by the German Practitioners' Association. The Central Committee, who are responsible for the form of the warning, describe the condition of the medical profession as "difficult and perhaps unfavourable" and its prospects as sad. They attribute this to three causes, the overcrowding of the profession, the abolition of anti-quackery laws, and recent legislation dealing with workmen's insurance. The number of medical men has doubled since 1876, while the number of unqualified people who practise medicine has enormously increased. According to the Committee members of the criminal class are largely concerned in bogus practice, and not only collect patients by unscrupulous advertisements, but actually get up meetings for the purpose of publicly vilifying medical men. It is somewhat strange that in a country such as Germany whose people are supposed to be clear-headed, logical, and intelligent, swarms of even cultivated persons flock to these quacks. Should the State continue to refuse to intervene to protect the interests of those whom they have licensed, one of two results are bound to follow. Either the number of those who seek to become qualified will greatly diminish, with the result that a smaller body of professional men will be able, owing to the

absence of undue competition, to maintain the status of the profession, or, the numbers entering will be kept up, but the intelligent and well-educated student will cease to join the profession. In the latter case, the status of the medical profession in Germany will become poorer each year, and the general public will be the first to suffer.

#### The Protection of the Holiday Maker.

AUGUST is the great holiday month for the million. Custom and convenience have established this period of the year as the season for life's physical renewal. Judged from the physiological and hygienic standpoint much might be said in favour of a re-arrangement of the year's recreation days. But at least in this matter the wishes of the majority must be respected. Life, it would seem, cannot be controlled in all its bearings by the stern commands of science. But whoever the holiday maker may be, and wherever he may choose to go for his mental rest and bodily renewal, science may well insist that reliable measures should be taken to protect him from the evil results of his own ignorance and folly. At present much disaster accrues to many from the non-hygienic commissions and omissions of the holidays. Even the strictest and most careful of would-be sanitarians at this season of the year oftentimes seems to throw discretion to the winds and plunge into extravagances and excesses unwarranted. But the sowing of recklessness speedily brings a harvest of regrets. The conduct of a holiday calls for much discrimination, wise discernment, and painstaking arrangement. We believe medical men might well exert a greater influence in instructing those to whom they stand in the responsible position of medical advisers as to the management and control of a hygienically-directed holiday. The haphazard method of selecting a resort, taking rooms, travelling thither and then drifting with the tide of a vulgar multitude in the pursuit of so-called enjoyment, cannot be too strongly condemned. Every medical man knows that the annual holiday is a fruitful season for the propagation of many forms of infectious disease, the initiation of not a few serious morbid conditions and the wasteful expenditure of much human energy. An injudiciously-conducted holiday oftentimes requires a second rest and recreation period under medical supervision to rectify ills which might well have been avoided.

#### Sundown Literature.

A PAPER which was recently read before a Medical Editors' Association in America, with the suggestive title of "Sundown Journalism," contains several important truths on the causation of much of the weakness of medical literature at the present day. Sundown work is work done after and in addition to the ordinary labours of the day; it may, in the case of the budding medical

man, be started at a "sundown college" and after he has become qualified may be continued in "sundown literature." "It is the work done when the brain and body are debilitated and below par from the strains and labours of the day." According to the writer, many of the American journals and medical works contain marked examples of sundown literature stimulated by drugs, and characterised by a jarred and exclamatory style from the effects of alcohol, or by the softer notes and the assertive confidence in which conclusions are stated under the influence of morphia. "The cocainist influences on these contributions are more pronounced than that of any other drug, particularly in the endless repetitions and involved explanations, and movement in a dreamy, hazy mass of words." We further learn that one of the popular text-books on the market is notoriously a midnight work, stimulated by opium and cocaine, while another with a large sale has drug writing and drug work on every page. We can quite believe that the evil of which the writer complains is by no means infrequent, but we doubt that it is as universal as he seems to think. In these countries it is certainly the isolated exception. In America, where life is altogether more hurried and more feverish, it is only reasonable to suppose that resort to stimulants of various kinds will be more frequent. The necessary end of such a course is visible from the start, and is one against which it should not be necessary to warn the medical man.

#### A Chicago Oculist's "Cure" for Intemperance.

IN these modern days medical science has developed a marvellous faculty for detecting the remote origin of this, that, or the other sign, symptom, or abnormal mental or bodily condition. One man studies uric acid with rapt attention, until he ends by ascribing every woe that afflicts humanity to the presence of that evil substance in the tissues. Another detects gout in every patient who consults him, and writes a terrified treatise on "Gout in its Protean Aspects." A third finds an explanation for nineteen-twentieths of all disease in disordered nerves and nerve action, including the hereditary taint of inebriety. The most comprehensive and persevering faddist of latter days, however, is the oculist who traces a myriad maladies to errors of refraction. Hath a patient epilepsy, asthma, herpes, migraine, tic, neurasthenia, headaches, baldness, dyspepsia, tremors, with a number of other complaints, ranging from deafness to dementia?—then let him forthwith seek relief and cure in suitable spectacles. The only thing hitherto sacred to the oculist has been drunkenness, but he has now stormed the last fort. A Chicago oculist has lately published his discovery that inebriety is merely a question of sight. The man whose sight is perfect does not get drunk, and *vice versa*. The matter, perhaps fortunately, can be determined absolutely one way or the other by actual experiment. Two sets of

patients, one with normal and the other with abnormal eyeballs, can be supplied with full doses of alcohol, and the results carefully noted. In order to avoid possible complications the experiments should be conducted in wards with carefully secured doors and windows.

UNDER the will of Mr. C. J. Shaw, of Leamington, the Birmingham General Hospital and the Warneford and Leamington General Hospital each receive a legacy of £2,000; and the Midland Home for Incurables, £1,000. The Stroud General Hospital and the Gloucester General Hospital each receive £300, under the will of Mrs. Winterbotham, of Dursley.

#### PERSONAL.

FROM a trustworthy source we learn that Sir William Turner intends shortly to resign the Presidency of the General Medical Council, and that its next meeting will probably be the last under his chairmanship.

IT is announced that Sir Thomas Barlow and Dr. H. D. Waller have been appointed representatives of the University of London at the International Medical Congress to be held at Lisbon in April, 1906.

PROFESSOR KÖNIG is about to vacate the Chair of Surgery in the Berlin University, the succession to which has, we understand, been declined by Baron von Eiselsberg, the Vienna Professor.

THE report that Professor von Leyden intends to resign his Chair in the University of Berlin has been contradicted.

DR. ALBERT S. GRUNBAUM, Lecturer in Experimental Medicine at the Liverpool University, has been appointed Professor of Pathology and Bacteriology in Leeds University (Yorkshire College) in the place of Professor Trevelyan, who is retiring at the end of September.

WE understand that Mr. Mayo Robson was sent for to operate on M. Waldeck-Rousseau, late Prime Minister of France. He had, however, left London on his way to America at the time, and the operation was performed by Dr. Kehr, the German specialist, assisted by Mr. Armour, Mr. Robson's assistant. Unfortunately, the illustrious patient was in too feeble a condition to combat the effects of the operation, to which he shortly succumbed.

DR. WILLIAM GAYTON has been presented by his colleagues with a handsome testimonial on his retirement from the medical superintendency of the North-West London Fever Hospital, after thirty-four years service under the Metropolitan Asylums Board.

THE Duke of Westminster has subscribed £1,000 towards the fund being raised for paying off the building debt in connection with the Alexandra Hospital at Rhyl.

MR. W. A. H. NAYLOR, F.I.C., F.C.S., of London, is the new President of the British Pharmaceutical Conference, which has just held its forty-first annual meeting, under the Presidency of Mr. T. H. W. Idris, J.P., L.C.C.

A CONSULTING-ROOM thief last week paid a professional visit to Sir Stephen Mackenzie, of Cavendish Square, but was quickly run to earth in a mews hard by on bolting from Sir Stephen's house.

PROFESSOR OSLER will preside at a Congress to be

held in the Medical Department of the World's Fair at the St. Louis Exposition on September 20th. There are twelve sections, presided over by distinguished men from various countries.

MADAME ALBANI will give a concert in aid of the Royal Hants County Hospital, on October 7th. The institution is one of the oldest of the kind in existence.

MR. W. J. CURRIE, of Glasgow, presided over the eighteenth annual meeting of the Federation of Local Pharmaceutical Associations, held last week in Sheffield.

### Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENT.]

#### BELFAST.

MEDICAL ATTENDANT ON THE ROYAL IRISH CONSTABULARY.—Dr. Alexander Montgomery has been appointed one of the medical attendants to the police force in Belfast, in place of Dr. H. M. Killen, resigned. As mentioned in this column last week, there was great competition for the appointment, which is said to be worth about £200 per annum. The selection of Dr. Montgomery for the post is a very popular one.

PORTRUSH COTTAGE HOSPITAL.—A two-day bazaar was held in Portrush last week to provide funds for the furnishing and equipment of the new Cottage Hospital, which has been provided mainly by the generosity of one lady. The Provost of Trinity College, Dublin, was in the chair at the opening ceremony, and made an excellent speech on the subject of the necessity which had arisen for small hospitals in country districts, as well as large institutions in the towns. Dr. J. C. Martin also spoke, and pointed out that Dr. Traill was the first medical man to occupy the important post of Provost of Trinity.

THE SMALL-POX EPIDEMIC IN ULSTER.—During the past week four fresh cases of small-pox occurred in Armagh, and were promptly isolated, and all contact cases looked after. One case has occurred in Monaghan, and the local authorities there, too, are anxiously watching suspects. The people are coming in hundreds for revaccination, and for a few days many had to be refused owing to the small supply of lymph. A plentiful supply is now to be had. Only one new case has been discovered in Belfast during the last ten days, and it is hoped that the worst of the outbreak is now past. Eight cases remain under treatment at Purdysburn Hospital.

PROPOSED MEMORIAL TO DR. McKEOWN.—A meeting was held in Belfast last week to consider the question of a memorial to the late Dr. McKeown, and it was decided that such a memorial was desirable, and a small committee was appointed to make arrangements for it. The senior members of the medical profession are mostly on holiday just now, and the meeting was chiefly a lay one. Emphasis was laid on Dr. McKeown's services to the cause of education in Ireland, and specially to his efforts to improve the conditions of the national schools.

### Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The diminishing birth-rate is a matter for scientific investigation and full, fair, and orderly discussion. Dr. Taylor has advanced the theory that the fall in question is due to "preventive methods" among married folk, and that these methods are harmful alike to parents and to their non-prevented offspring. My articles in your issues of July 13th and 20th examined the grounds upon which Dr. Taylor based his conclusions. I am no advocate of preventive practices—

Heaven forbid!—but my investigation showed to my own satisfaction that there was not sufficient evidence either that in the United Kingdom the fall was due to preventive practices, or that parents and non-prevented offspring suffered from the practices in question.

Your correspondents, Dr. Drysdale and "A Student of Sociology," go outside the issues raised in the discussion, although their letters are interesting and valuable.

Dr. Taylor implied that it was the duty of married people to produce children indefinitely, regardless of means, of bodily or mental fitness, or of any other factor of environment.

Dr. Taylor on July 27th wrote thanking Dr. Drysdale for dealing with the first part of my paper. Dr. Drysdale supported the view that the fall in the total birth-rate is altogether due to preventive practices. I venture to say that he does not dispose of my argument that the fall is due mainly to other causes. Dr. Taylor, however, classes me with Dr. Drysdale as an advocate of preventive methods, which is unfair and unjust. He then says I fall into a greater fallacy than that which I think I am exposing. The "fallacy" which he seeks to place upon my shoulders in *tu quoque* fashion I fail to comprehend, but gather it has something to do with the suggestion appropriated from my paper that the fall in illegitimacy may be more or less due to the use of preventive methods. In any case, there is no need for him to introduce fresh matter.

Such grounds, Dr. Taylor says, dispose of the "first twelve of my so-called conclusions." I venture to think, however, that a scientific question cannot be dismissed in that cavalier fashion by blinking awkward criticisms and, so to speak, knocking together the heads of one's opponents. Nor are Dr. Taylor's other thrusts and parries more convincing.

I suggested the question of the falling birth-rate in the United Kingdom might well be investigated by a Royal Commission. Dr. Taylor asks if I do not know a Royal Commission has sat on the subject in New South Wales. He might as well refer me to any other Royal Commission of Inquiry on any other subject in any part of the world. Social and economic conditions in New South Wales and in the Mother Country are as chalk to cheese.

Then, again, in your issue of August 10th, Dr. Taylor expresses sorrow for the unnecessary trouble caused to himself and to a "kind correspondent" by Dr. Walsh's mistake in giving 31 as (approximately) the total birth-rate for the *United Kingdom* in 1884. That statement Dr. Taylor and his friend seek to controvert by quoting the total birth-rate for *England and Wales* in 1884, namely, 33'6. It grieves one to see so much sorrow run to waste. It is still more saddening to find inaccuracy of the kind shown by Dr. Taylor and his friend figuring in the columns of a scientific journal.

Truth is truth. The laws that govern the rise and fall of birth-rates will doubtless one day emerge from the mist of futilities in which they are now enshrouded into the full light of knowledge. Meanwhile, irrelevancy and intellectual slovenliness will not mend matters. If Dr. Taylor's views are right they are capable of proof by ordinary recognised methods of formal argument. It is for him to make good his case against all comers.

I am, Sir, yours truly,

DAVID WALSH.

Hanover Street, London, W.

#### SUPERSTITION AND PSYCHOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter by Mr. H. Rider Haggard to the *Times* on "Telepathy between a Human Being and a Dog," which you criticised in an able leader on August 3rd, has been followed by another lengthy communication in the same newspaper of August 9th. If the name appended to these letters had not held a place in literature it is hardly possible they would have found admission to the pages of your great contemporary. They may be literature, they are

certainly not science. From the scientific point of view both the letters are equally beneath serious attention. The point of interest, as these letters once more show, is, that there exist vast masses of the people, hardly less numerous among the so-called cultured than among the uneducated classes, who are absolutely ignorant of science and of scientific methods, and as credulous in all questions of natural phenomena as their ancestors who believed in witchcraft, and in the constant occurrence of miracles in the events of daily life. Mr. Rider Haggard apparently sticks to his opinion that the circumstances of his dog's death were communicated to him by telepathy in some form, and seriously discusses the following suggestions to account for the fact:—

- (1) That his own spirit or sub-consciousness travelled to the place and saw the things happen.
- (2) That the telepathic information, considerably delayed in transmission, came from the brain of a human being who witnessed the death of the dog.
- (3) That this is an instance of deferred telepathy, the communication coming from the dog and acting upon his mind hours afterwards in his sleep.
- (4) That his own clairvoyance was the cause.
- (5) That the dog's astral shape visited him.

Mr. Rider Haggard, after critically examining these hypotheses *seriatim*, rejects them all in favour of his previously expressed opinion, that "This curious happening must have been due to some non-bodily but surviving part of the life or of the spirit of the dog." Mr. Rider Haggard declares that his dog Bob was superior to some degraded human beings, and if these beings, as he believes, are "possessed of an immaterial part called a spirit" he does not know why Bob "should not have a spirit also," and why that spirit as it departed hence should not have re-produced in Mr. Haggard's consciousness, "with which in life he was so familiar, the dramatic circumstances of his end, or as much of them as he considered necessary and important"!! Mr. Rider Haggard "does not say that this is so," he can only say he can see no overpowering religious or practical reason to the contrary. Everyone will agree that if an argument is built upon a foundation of pure hypothesis unsupported by a single scientific fact, and mostly revolting to a trained intellect, it matters not what crowning absurdity be accepted to conclude the argument; and if we accept Mr. Haggard's facts and hypotheses we can all admit the possibility of causation of his nightmare to lie in a visitation by the spirit of his faithful dog-friend Bob.

I am, Sir, yours truly,

August 10th, 1904.

H. S.

#### PREVENTION OF PERINEAL RUPTURE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Like Dr. Duke, I regarded Laphorn Smith's method, referred to in your issue for August 3rd, as ridiculous in the extreme. My object in writing now is to endorse your correspondent's treatment of the perinæum with the object of preventing rupture. I was not aware, until I read Dr. Duke's letter, that anyone had actually suggested a plan of treatment which I have always employed. There must surely be a good deal of intuition in the practice of medicine, for I adopted the method of retracting the perinæum on my own initiative.

I go further, however, than Dr. Duke, for I not only retract the perinæum *during* the uterine contractions, but also *between* the pains. The perinæum being a very elastic structure, it yields readily to traction, and my plan is to pull upon it with either two or three fingers in the vagina. When the perinæum is at all rigid (which is, after all, quite an exceptional occurrence) the administration of a little chloroform greatly aids the carrying out of this procedure, as thereby the parts are made more yielding.

The result obtained by the retraction method is that the head is not forced down on the perinæum during the pains to such an extent as it is when the perinæum is not retracted. The passage of the head is thus

facilitated, and this, I think, is an additional advantage besides that of prevention of perineal rupture.

I am glad to know that my own practice is endorsed by such a valued authority as Dr. Duke.

I am, Sir, yours truly,

JAMES BURNET.

20 Polwarth Crescent, Edinburgh.

August 10th, 1904.

#### METEOROLOGY AND HEALTH RESORTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have before me an article on "Meteorology" (July 3rd, 1889) in THE MEDICAL PRESS AND CIRCULAR. In this present week's number of this journal, August 10th, 1904, there is, on p. 144, a report upon Teignmouth as a health resort; and on p. 159 a notice of Dr. Burney Yeo's book on the "Therapeutics of Mineral Springs and Climates." The most important point to be attended to when dealing with the climate of a place is the nature of the soil. In the article on meteorology we read, "In evidence of this we observe that a committee has been appointed by the Medico-Chirurgical Society, &c.," and in the notice of Dr. Yeo's book we read that the report, "although good in intention, failed to attract the notice which from the reputation of the contributors it deserved." The report did not deserve notice, for it did not follow the principles laid down in the article of July, 1889, and was practically of no value; hence its fate.

It is to be regretted that under the heading "British Health Resorts" there has been shown the same want of scientific and practical knowledge which is absolutely necessary for those who attempt to analyse the value of health resorts. It is to be regretted that this subject is so little understood and is so feebly treated.

I am, Sir, yours truly,

Kensington, August 12th, 1904.

R. L.

#### Obituary.

SIR WILLIAM MITCHELL BANKS, K.C.B., M.D., F.R.C.S.

GREAT regret was occasioned in Liverpool on the receipt of a telegram announcing the sudden death from angina pectoris, of Sir William Mitchell Banks, the distinguished surgeon, who was spending a holiday on the continent. Sir William Mitchell Banks, M.D., F.R.C.S. and a Justice of the Peace for the city of Liverpool, was in his sixty-second year at the time of his death. He was the son of Mr. Peter S. Banks, a well-known Edinburgh solicitor, his mother being the daughter of a Liverpool merchant. The future surgeon was educated in Edinburgh Academy and University. In 1864 he took the degree of M.D. with honours, gaining the University Gold Medal for an anatomical thesis on the Wolffian bodies. He obtained his degree at Edinburgh of LL.D. in 1899. He acted as Demonstrator of Anatomy in the Glasgow University for two or three years, and then settled in Liverpool as an operating surgeon and teacher of anatomy. He soon made his mark, and for many years he has been regarded as one of the foremost surgeons in the Kingdom. In addition to an extensive private practice, he was surgeon to the Liverpool Royal Infirmary, in the establishment of which he spent much time, and gave a great deal of valuable help in a variety of ways. The University College, now the Liverpool University, is another local institution which benefited extensively from his advice and assistance. Other directions in which Sir William found an outlet for his great skill were on the General Medical Council and on the Council of the Royal College of Surgeons of England. One of his most notable works was in connection with the recent development of the Medical School of Liverpool. He took little or no active part in public affairs. His name is especially associated with the advocacy of extensive operative measures for the removal of cancer of the breast and with attempts to discover the most suitable operation for the radical cure of rupture.

SIR FREDERICK BATEMAN, K.C.B., M.D.,  
LL.D., J.P.

It is with sincere regret we announce the death of Sir Frederick Bateman, in the 81st year of his age, on the 10th instant, at his residence, 70 St. Giles' Street, Norwich. Death was due to heart failure, apparently connected with the recent hot weather. Two days before his death he introduced his successor at the Norwich Bethel Hospital, an institution with which he had been connected for more than thirty years. He was the son of a leading Norwich citizen. His first professional post was that of resident surgeon to the Norfolk and Norwich Hospital, to which he was appointed surgeon in 1851, and where he was a student in earlier years. In one capacity and another he was connected with the institution for over sixty years, and he held the position of consulting physician, an appointment conferred upon him at the close of his term of duty as senior physician. Up to the time of his death he was also consulting physician to the Eastern Counties Asylum, at Colchester, an institution in which he took the warmest interest, the Norfolk and Norwich Eye Infirmary, the Jenny Lind Infirmary for Sick Children, the Norwich City Asylum, and the Bethel Hospital—in the case of the latter for thirty years. For a long time he was prominently connected with the public life of his native town. In 1872 he was appointed Sheriff, and in 1892 he received the Queen's Birthday Honour of Knighthood. In 1855 he married Miss Emma Brownfield. He leaves three sons, all living, and all holding honoured positions in the medical profession. Sir Frederick Bateman supported in an eminent degree the traditions that have made Norfolk famous in the annals of medical science.

WILLIAM HOLLOWAY, M.D.LOND., A.M., M.R.C.S.

We regret to announce the death of Dr. William George Holloway, of Hertford Street, Mayfair, an authority on diseases of the throat and nose, at the early age of forty-three years. Educated at Sidney Sussex College, Cambridge, and at St. Mary's Hospital Medical School, he took his B.A., with a first class in the natural science tripos in 1883, and his M.B. with a first class in the second examination in 1886. He was a scholar of St. Mary's Hospital in 1884-85, was admitted a member of the Royal College of Surgeons, England, in 1885, and was prizeman and scholar of St. Mary's in several subjects in 1885-86. In 1890 he proceeded to the M.D. degree. Dr. Holloway had been house surgeon to the St. Leonards and East Sussex Hospital and house physician to the General Lying-in Hospital, Lambeth. He was subsequently for many years connected with the Central London Throat, Nose, and Ear Hospital as clinical assistant, afterwards as pathologist, registrar, and anaesthetist, and finally as senior assistant surgeon. He was a fellow of the British Laryngological and Rhinological Association and a member of the Harveian Society of London and of the British Medical Association.

JOHN RUXTON, M.D.ABERD., OF BLACKPOOL.

DR. RUXTON died suddenly on August 5th at his residence, North Shore, Blackpool. The deceased, who was 56 years of age and married, went to Blackpool about twenty-one years ago. He was one of the consulting surgeons at the Victoria Hospital, Blackpool. Dr. Ruxton lived a somewhat retired life, and took no part in public affairs. His medical education was conducted at Aberdeen, where he graduated M.B., C.M., in 1869, and M.D. in 1883.

JOHN HENRY GREENWAY, R.A.M.C.

THE death is announced of Major John Henry Greenway, of the Royal Army Medical Corps, who died on August 8th, at Wynberg Camp, Cape Town. Major Greenway, who was born in 1857, after completing his education at Guy's Hospital and taking the degrees of L.S.A. and M.R.C.S.Eng., joined the Army Medical Corps in 1885, and attained the rank of Major in 1897. He served in the Orange River Colony during the South African War.

Literature.

ORGANIC NERVOUS DISEASES. (a)

THE need of a thoroughly trustworthy work on diseases of the nervous system, dealing exhaustively and critically with the subject, has long been felt. It is the most difficult and complex portion of the medical curriculum, and its literature is scattered widely over isolated papers in monographs not always easy of access. Dr. Allen Starr is a neurologist of repute, whose contributions have for many years attracted attention, and whose name is as familiar in London as it is in New York. There is no one better fitted, either from familiarity with the history of the subject or from personal experience, to fill the hiatus, and the result of his attempt is a book of 750 pages, profusely illustrated with original engravings and plates in colours and monochrome. A good way of judging of the value of a work on any special subject is to select some particular disease, preferably one of common occurrence, and by careful examination to ascertain how far it comes up to one's ideal. We take as an example locomotor ataxy, tabes dorsalis, or posterior sclerosis. The first thing we notice is, that the author enters into no discussion as to the relative advantages of these terms, and that there is no section devoted to nomenclature. This is but a small omission, and is perhaps hardly worth mentioning. Much more important are the questions of morbid anatomy and pathology, both of which are admirably rendered, all the most recent observations and theories being described in detail. Under the head of etiology there are references to the influence of syphilis in the production or causation of tabes, and the author adduces many arguments against its being of syphilitic (? parasymphilitic) origin, although a predisposing influence in a large number of cases is admitted. It is rare to find tabes in Japan or in China or among the negro races, and yet syphilis is common enough among these people. The symptomatology of tabes is given at considerable length, and we have never before met with an equally comprehensive account of the subject. The less of knee-jerk is, of course, referred to, but is not spoken of as Westphal's sign. The term "iridoplegia" is not mentioned as a synonym of the Argyll-Robertson phenomena. The various crises are well described, including the laryngeal vertigo of Charcot. The author has not seen the gastric crises of the French writers, and does not mention the clitoridectian crisis which accounts for the curious perverted sexual manifestations sometimes met with in erotic women. The Charcot joints are illustrated and an excellent engraving is given of the perforating ulcer of the foot. The author speaks of subluxation with reference to certain joints, but does not employ the term hypotonia. The mental condition is described at some length, the author recognising that there is a close connection between tabes and general paresis. A useful section is devoted to the rarer symptoms of the disease, which might well form the bases of a good examination question. The pages on the treatment of this common and intractable disease are not only thoroughly practical, but are more complete than will be found in any other treatise. We have applied a somewhat severe test, and Dr. Allen Starr has more than answered our expectations.

Turning now to another subject, we find no mention of Morvan's disease in the index, but under the head of "Syringomyelia," there is not only a reference to Morvan's original paper, but a full description, with an excellent and typical series of illustrations showing the trophic change in the hands.

Gilles de la Tourette's disease we do not find mentioned, but it is probably excluded on the ground that it is not due to a gross organic lesion, and is purely functional in character.

The difficult subject of neuritis is dealt with at considerable length. Multiple neuritis first receives

(a) "Organic Nervous Diseases." By M. Allen Starr, M.D., LL.D. Professor of Diseases of the Mind and Nervous System in the College of Physicians and Surgeons of Columbia University, New York. London: Baillière, Tindall and Cox. 1904. Price 25s. net.

consideration, and attention is then devoted to alcoholic neuritis, arsenical neuritis, the multiple neuritis due to poisoning by lead, and other analogous forms. We are glad to find that the neuritis which sometimes follows the administration of sulphonal and trional is alluded to. Under various headings are considered the multiple neuritis of diphtheria, the form accompanying or following attacks of influenza, leprosy neuritis, and the epidemic multiple neuritis known as beri-beri or kakke. All these are described and discussed at considerable length, and much attention is devoted to their treatment.

Other useful chapters deal with such subjects as the diagnosis and location of brain diseases, syphilis of the nervous system, and the muscular dystrophies.

We are greatly pleased with this work, which is probably the best and most comprehensive volume on organic nervous diseases in any language.

#### SURGICAL BANDAGING. (a)

THE author in writing this small work has endeavoured to provide a ready and complete pocket reference book for junior students and nurses in surgical wards.

The book opens with a chapter on the modern treatment of wounds. The older methods of treatment are briefly alluded to and contrasted with those in use at present. The bacteriology of the subject of wound infection is gone into sufficiently to make the treatment of wounds and the reasons for asepsis and antiseptics quite clear. The various antiseptics in use are mentioned and discussed; we would, however, like to see lysol included in the list. Full details of the methods of sterilising dressings and instruments are given. The following occurs on page 21:—"During the process of sterilisation the thermometer should make a heat of 120° F. at least." We did not know before that a thermometer was capable of producing heat, but we would like to see the minimum temperature considerably over 120° F.

The author, in Chapter VI, dealing with the preparation of the patient for operation, says: "The usual steps having been taken to empty the lower bowel." He seems here to forget that he is describing things for the uninitiated.

Several chapters are devoted to bandaging and splints. The various methods and forms are well illustrated and described.

In the chapter on "Nursing in Cases of Injury," much useful information is given for injuries of the different parts of the body.

The book concludes with a chapter on "The Temperature and Pulse," in which the following requires some explanation:—"The pulse should not always be taken on the same side. In some cases the pulse on the right side is slower or more rapid than that on the left side, and there may be other irregularities."

On the whole the book for its size is complete, and one which junior students and nurses will find very handy and useful.

#### LAKE ON DISEASES OF THE EAR. (b)

THIS is an excellent handbook for advanced students and general practitioners, and is published at a very moderate price. Mr. Lake wisely restricts his first chapter to a "brief description of the more important anatomical points," neither plunging into too profuse descriptive details, nor yet scamping the really important ones. The next two chapters are devoted to the general and special examination of the patient, and under the latter heading the author sounds a note of warning as to a cautious prognosis of the curative effect of intra-nasal surgery on aural diseases. During past years intra-nasal surgery appeared to be a panacea

(a) "Practical Guide to Surgical Bandaging and Dressings." By Wm. Johnson Smith, F.R.C.S., Principal Medical Officer, Seamen's Hospital, Greenwich. Pp. 167 and viii, with 70 illustrations. London: The Scientific Press, Limited, Philadelphia: J. P. Lippincott Co.

(b) "Handbook of Diseases of the Ear for the Use of Students and Practitioners." By Richard Lake, F.R.C.S. Eng., Surgeon, Royal Ear Hospital, Lecturer on Practical Otolaryngology, Medical Graduates' College. Pp. x and 32, 54 illustrations and three coloured plates. Crown 8vo. Price 6s. net.

for most human ills, but we are glad to find that the tide is turning and that it is being limited to its own sphere of undoubted usefulness. The "estimation of the acuteness of hearing" and "the use of instruments" are very well done, but the forceps for cleansing the ear (Fig. 21) would be more useful if curved as in the illustration of Grüber's carrier (Fig. 24), so that the hand of the operator holding it may be kept well out of the path of the light from his head mirror. Diseases and malformation of the external ear, diseases of the middle ear, acute, chronic suppurative and non-suppurative, have each chapters in which their various forms are described as fully as the limits of the book allow. Two very good coloured plates are given of chronic non-suppurative and suppurative diseases of the middle ear; and the intra-cranial complications of the latter have a chapter to themselves, as has the influence of diseases of the middle ear on life assurance.

A useful appendix and index are added. The printing, binding, &c., are well done.

### Literary Notes and Gossip.

DR. ARTHUR H. RIDEAL has had reprinted from the *Army and Navy Gazette* of February 13th last, his article on "National Physique and an Ideal Army." The scheme he suggests is that all boys should be compulsorily trained with a view to their military usefulness as Volunteers in the event of national danger. He calculates that in eight years from the initiation of the scheme there would be more than a million well-trained young men at the service of the country in case of need, and that in course of time every able-bodied man in the Kingdom would be sufficiently trained to take up arms at once in defence of the Empire.

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RECENT mishaps as regards the leaving of instruments in the abdominal cavity have caused much commotion, both inside and outside the medical profession. As it seems clear that the surgeon cannot trust the ordinary methods of checking instruments used at an operation, it will be wise to adopt some system whereby exact written dates can be referred to at a glance. Such a plan is offered in the "*A B C Instrument Check Book*," designed by A. E. S. Waters, M.R.C.S. Eng., and published by Sharman and Co., of March. It has a heading space for name of patient, date, and other details, followed by a list of instruments, with their number, both before and after operation. At the foot is a blank space for the signature of the person responsible for the instruments. The idea is a good one and well carried out.

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MESSRS. W. B. SAUNDERS AND Co. announce that the new (second) edition of Pusey and Caldwell's work on "Röntgen Rays in Therapeutics and Diagnosis" will be ready in about two weeks, the first edition being exhausted. The new edition will be increased by about 100 pages, and the case histories will be brought down to date. The price of the work will remain as heretofore, 21s. net. The same firm will also publish in the autumn an important new work on the "Vermiform Appendix and its Diseases," by Dr. Howard A. Kelly.

\* \*

It is officially announced that the *London University Gazette* will appear at longer intervals than hitherto. Eleven numbers, instead of twenty, will be published in the course of the Academic year, on Wednesdays, at average intervals of four weeks. The first will be issued on September 28th, 1904; and the dates of the other numbers will probably be,—November 9th, December 7th, December 28th, February 8th, March 8th, April 5th, May 31st, June 21st, July 19th, and August 9th.

\* \*

WE have received three interesting booklets in paper covers from the "Simple Life Series," published by A. C. Fifield, of Fleet Street, London. No. IX is the classical "Walden, My Life in the Woods," by



H. D. Thoreau; No. X. "Tolstoy as a Schoolmaster," by Ernest Crosby; and No. XI "Master and Man," by Leo Tolstoy. The price of each volume is sixpence only, yet the printing, paper, and publishing are of first-rate excellence. Our readers could hardly make a better investment as regards cheap reproductions of good literature. No. XIII of the same series costs threepence. It is the well known essay of Ralph Waldo Emerson upon "Culture."

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THE Orthops Test Chart is a convenient combination for the consulting room. It measures forty inches by twenty-five inches, and contains:—(a) An arc of radiating bars; (b) a series of Snellen's test types; (c) a revolving astigmatic diamond, and (d) a muscle test. The arrangement and size of the bars and the spaces between them on the revolving disc and the radiating arc are such that a small degree of astigmatism can be made manifest, and the principal meridians determined with great exactitude. The figures of the muscle test are printed on one side in red and the other in green. The chart being a combination of various charts, it occupies a minimum of wall space. The chart has been designed by Mr. Lionel Laurance, and is published by Messrs. Storey and Co., of Leeds.

### Laboratory Notes.

#### DIGITALONE.

MEDICAL men frequently complain of irritation following the hypodermic injection of digitalin. Moreover the preparations placed on the market as digitalin vary greatly in composition and in physiological activity, some of the commercial products consisting of digitoxin, or mixtures of digitoxin and digitalin. To overcome these defects and to provide a preparation perfectly suitable for hypodermic use, Parke, Davis and Co. have introduced digitalone, a non-alcoholic, non-irritating, aseptic and permanent solution, representing all the principles of digitalis, of uniform physiological activity, and standardised by physiological assay. The solution is sold in one ounce bottles, equal in strength to one-tenth that of the fluid extract, or four-fifths that of tinct. digitalis B.P., the dose hypodermically being eight to fifteen minims. It supplies a real everyday want of the busy practitioner, to whose notice it may be cordially recommended.

### Medical News.

#### Morphia Poisoning.

A YOUNG medical practitioner, named Dr. Benjamin Gowing, has died at the Belle Hotel, Maidenhead, under singular circumstances. Dr. Gowing had been missing from his home near Swansea for nearly a week, and at the inquest on Saturday it was stated that it was not known what led him to go to Maidenhead, unless it was to see his stepmother, who was on a visit to the district. A brother-in-law said that Dr. Gowing was in pecuniary difficulties, and was paying the purchase money of his practice by instalments. The jury returned a verdict of death through taking an overdose of morphia by misadventure.

#### Small-pox in a Prison.

SMALL-POX has broken out in the county prison at Worcester, and two prisoners affected with the disease have been removed to the isolation hospital.

#### Cholera in St. Petersburg.

THE *Petit Parisien* says that there have been about 150 cases of cholera in St. Petersburg during the last two days, and much alarm exists among the population. The Prefect of Police, General Foulon, has taken severe measures to crush out the epidemic, which, however, is asserted not to be Asiatic cholera but a relatively benign form of the malady.—*Times*.

#### Small-pox at Buxton.

THE *Buxton Chronicle* announces that six cases of small-pox have broken out at Hyde, and one of the patients, an old lady in her 80th year, has died; the other patients are expected to recover. This is one of the most extensive outbreaks that Hyde has experienced for several years, as the town has generally been very free from the scourge. The sanitary authorities have taken steps to confine the outbreak. After immunity for several weeks, a fresh case has been discovered in the Ashton district.

### PASS LISTS.

#### University of London.

THE following candidates have passed the general Intermediate Examination for internal students in the Faculty of Medicine (alphabetically arranged):—Ella Mabel Barker, Charles Anthony Basker, Harold Garfield Bennett, Sylvia Rose M. Blackstone, Mary Alice Blair, Harry Blakeway, Gerald Tyler Burke, Thomas Wm. Higgins Burne, Angel Camacho, Thomas E. Ashdown Carr, Henry Joseph Cates, Herbert Stanley Chate, Bertram Walter Cherrett, Arthur Beauchamp Coomber, Herbert Rees Davies, Kenelm Hutchinson Digby, Reginald Lionel Ernest Downer, Sheldon Francis Dudley, Robert Cecil Turle Evans, Marmaduke Fawkes, Allan Baines Fearnley, Wm. Stephen Fenwick, Janet Marcia Fische, Alexander Fleming, Sidney Frank Fouracre, Ernest William Giesen, Sidney Wilfred Grimwade, Edith Mary Guest, John Hadwen, Eric Henry Rhys Harries, Henry John Henderson, Tom Shadick Higgins, John Ernest Hodson, Hendrik Houwink, Douglas Walter Hume, Mary Sophia Jevons, Elizabeth Herdman Lepper, Clifford Anthony L. Mayer, Marian Mayfield, Minnie Merrifield, Ethel Mary Morgan, Wm. Poole Henley Munden, Frederic Miller Neild, Henry John Nightingale, Humphrey Nockolds, Edgar Lionel Robert Norton, Charles Aubrey Pannett, Walter Patey, Catherine Payne, August Frederick Perl, Arthur John Scott Pinchin, Edward John Price, Mona Dew Roberts, Richard Cadwaladr Roberts, Henry Charles Samuel, William Octavius Sankey, Marie Simpson, Eliza Macdonald Smith, Henry Joste Smith, George French Stebbing, Alfred K. B. R. W. Taylor, Douglas Compton Taylor, Alfred Chas. Foster Turner, James Richard Henry Turton, Winifred Emmeline Watts, Harry Gordon Webb, Leonard Henry Wootton, Carl Ernst Zundel.

The following have passed the Intermediate Examination in Medicine for external students:—

Laurence Ball, Sydney Herbert Booth, Ernest Frederick Finch, Robert Applegarth Hendry, James Ernest Middlemiss, Edward Selby Phipson, Harry Richardson Rawlings, Arthur Toulmin, Arthur Henry Turner and Joseph Wm. James Willcox.

#### Society of Apothecaries of London.—August, 1904.

THE following candidates passed in:—

*Surgery*.—R. H. Cooper (Sec. II), A. W. S. De Vine (Sec. I and II), E. F. W. Hoare (Sec. I and II), A. C. Story (Sec. I and II), and R. H. Terry (Sec. I).

*Medicine*.—G. B. Messenger (Sec. I), C. S. Scott (Sec. II), I. C. Thorburn (Sec. I and II), A. B. S. Todd (Sec. II), and S. H. R. Welch (Sec. I and II).

*Forensic Medicine*.—C. W. S. Boggs, E. F. W. Hoare, J. E. Jones, I. C. Thorburn, and H. M. Waller.

*Midwifery*.—W. G. H. Cable, and W. R. Elliott.

The Diploma of the Society was granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery—R. H. Cooper, A. C. Story, A. B. S. Todd, and S. H. R. Welch.

BARON HENRI DE ROTHSCHILD, of Paris, an M.D. of the University of Paris, who has attained celebrity as a physician in that city, and for several years has been a subscriber to THE MEDICAL PRESS AND CIRCULAR, has been promoted to be a Knight of the Legion of Honour.

## 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.

**DR. SCHEER (Algiers).**—Your interesting case of "neurasthenia and deep conscious troubles of sensibility accompanying a very slight and old hemiplegia" is marked for early insertion.

**MR. R. STEVENS.**—The population of London officially estimated to the middle of the present year is given as 4,648,950, but this refers only to the inner circle; including the suburbs it reaches 6,907,000. From official sources we also learn that at the same period of computation Glasgow had a population of 798,000, Liverpool 723,000, Manchester 567,000, Dublin 378,000, Belfast 358,000, and Edinburgh 331,000; all are increases on previous censuses, notwithstanding the "diminishing birth-rate."

### NOT YET EARNED.

"This is the bill from your oculist," said the collector to Mr. Grimly on calling for payment.

"Just take it back to him and tell him that I can't read it with those glasses he ordered me."—*N. A. Medical Review.*

**DR. H. S. E.**—(a) Monro's Manual of Medicine is the most practical single volume work on the subject with which we are acquainted. (b) *Whit's Therapeutics.* (c) *Moore's Meteorology.*

**MEDICUS ETONIENSIS.**—The latest improvement in the incubator rearing of premature infants is to supply oxygen more or less continuously. The chances of the survival of one of these fractional vitalities would obviously be multiplied in that way. We read lately that in New York a tea-party had been arranged for all the children, who had been introduced to the world *via* incubator. On this side of the Atlantic such a gathering would be extremely small. The dramatic nature of the method evidently appeals strongly to the instincts of our transatlantic cousins. There is no particular reason why our country practitioners should not mount to name and fame on the top of an incubator—quite the reverse.

### SLEEPING POTION FOR THE KING.

Zimmerman, who was very eminent as a physician, went from Hanover to attend Frederick the Great in his last sickness. One day the king said to him: "You have, I presume, sir, helped many a man into another world?" This was rather a bitter pill for the doctor, but the dose he gave the king in return was a judicious mixture of truth and flattery. "Not so many as your majesty, nor with so much honour to myself."—*Modern Eloquence.*

**C. H. S.**—The subject demands most careful and delicate handling. At the same time it is obviously true that many acts of religious fervour, historical and otherwise, have arisen from a disordered brain. Supernatural visions, prophecies, and a host of irrational objective and subjective phenomena may be traced to insanity. The reign of science is not yet altogether established in this branch of the world's moral and intellectual development.

**PATEROW, L. L. S.**—It is open to you to point out to your patient that he is paying 7s. 6d. a bottle for his patent medicine the actual value of which is about sixpence. The formula of the stuff is readily obtainable.

**E. K. DYNEVOR.**—Women medical students are not allowed to attend the University classes in Edinburgh and Glasgow, as they are at Aberdeen and St. Andrews, nor will the Colleges of Physicians and Surgeons admit women to fellowship. A special committee of lady doctors practising in Scotland has been appointed to promote the reforms desired.

## Vacancies.

**Aberaman, near Aberdare.**—A fully qualified Medical Man to take Charge of a large Colliery District Practice. Salary £400 per annum, with a free house, coal, assistants dispenser, drugs, &c. No private practice allowed. Applicants must be married. Applications to the Secretary, James Phillips, 10 Pleasant View, Godre Aman, Aberdare.

**North Cambridgeshire Hospital, Wisbech.**—Resident Medical Officer (unmarried). Salary £100 per annum, with furnished rooms, attendance, coals, gas, and washing. Form of application to William F. Bray, Secretary.

**St. Bartholomew's Hospital.**—Physician on the Staff. Candidates must be Fellows of the Royal College of Physicians of London. Applications to W. H. Cross, Clerk.

**Bootle, Liverpool, General Hospital.**—Senior Resident. Salary £100 per annum, with board and laundry. Apply by letter to the Secretary, Borough Hospital, Bootle.

**Royal Lancaster Infirmary.**—House Surgeon. Salary £100 per annum, with residence, board, attendance, and washing. Applications to be made only on a form to be obtained from the Hon. Secretary.

**Ebbw Vale Workmen's Medical Fund Committee.**—Senior Surgeon for the district of Victoria, near Ebbw Vale. Salary £500 per annum. Applications to Dr. Keith Campbell, Ebbw Vale, Mon. Cumberland Sanatorium for Consumption, near Threlkeld, Keswick. Resident Medical Superintendent. Salary £150 per annum. Apply Hon. Sec., 2 Brunswick Street, Carlisle.

**County Asylum, Rainhill, near Liverpool.**—Assistant Medical Officer to act as Locum Tenens for a few weeks. Salary £4 4s. per week, with furnished apartments and board. Applications to the Medical Superintendent.

**Birkenhead and Wirral Children's Hospital.**—House Surgeon. Salary £400 per annum, with board, residence, and laundry. Applications to E. H. Tibbey, Hon. Sec., 60 Temple Road, Birkenhead.

**Devon County Asylum.**—Required at once, an Assistant Medical Officer. Salary commencing at £125 per annum, with board and lodgings. Apply to the Medical Superintendent, Asylum, Exminster.

**Open-air Sanatorium for Consumptives, Limpley Stoke, near Bath.**—To be opened November next.—Resident Medical Officer. Salary £200 per annum, with annual increment £20 to £200. Experience in Sanatorial Treatment essential. Applications to "Chairman," N.A.P.O., 84 Park Street, Bristol.

## Appointments.

**BLAIR, JOHN, M.D.R.U.I.** Honorary Assistant Medical Officer to the Royal Albert Edward Infirmary, Wigan.

**BURTON, H. M.D.Durh., M.R.C.S.Eng., L.R.C.P.I., L.S.A.,** Certifying Surgeon under the Factory Act for the Marple District of the county of Chester.

**CLEVELAND, J. W., M.R.C.S., L.R.C.P.Lond.,** House Surgeon to the Royal Berkshire Hospital, Reading.

**FLAHERTY, J. G., L.R.C.P., L.R.C.S.I.,** Certifying Surgeon under the Factory Act for the Tubbercurry District of the county of Sligo.

**GREENE, ARNOLD J., M.R.C.S.Eng., L.R.O.P.,** Assistant Medical Officer to the Royal Albert Edward Infirmary, Wigan.

**KEMP, W., M.B., O.M.Édin.,** Certifying Surgeon under the Factory Act for the Castledorf District of the county of York.

**LEE, E. H.,** House Physician to the Richmond, Whitworth, and Harwicke Hospitals.

**MACCORMAC, HENRY, M.B., Ch.B.Édin.,** Assistant Resident Medical Officer to the Royal National Hospital for Consumption and Diseases of the Chest, Ventnor, I.W.

**MACLIN, T. E., M.D. Glas.,** Certifying Surgeon under the Factory Act for the Whalley District of the county of Lancaster.

**MACLEAN, EWEK J., M.D., M.R.O.P.Lond., F.R.S.Édin.,** Lecturer on Midwifery (under the Midwives Act) to the University College of South Wales and Monmouthshire, Cardiff.

**PERRIN, E. A., M.D.Lond.,** Certifying Surgeon under the Factory Act for the Whitchurch District of the county of Salop.

**POYNTON, F. J., M.D.Lond., F.R.C.P.Lond.,** Sub-Dean of the Faculty of Medicine, University College, London.

**REES, FERDINAND, M.D.Glas.,** Honorary Assistant Medical Officer to the Royal Albert Edward Infirmary, Wigan.

**RUTHERFORD, J. W.,** House Surgeon to the Richmond, Whitworth, and Harwicke Hospitals.

**SHELDON, HUGH, F., M.R.C.S., L.R.C.P.Lond.,** Civil Surgeon to the Military Hospital, Potchefstroom, Transvaal.

## Births.

**BEVAN.**—On August 6th, at Kensington Garden Terrace, W., the wife of Arthur Bevan, M.D.Lond., of a daughter.

**FALCONAR.**—On August 5th, at Tregenna House, Shirehampton, near Bristol, the wife of H. Barclay Falconar, Surgeon, of a daughter.

**HARRISON.**—On August 6th at the Priory, St. Neots, Hunts, the wife of Ernest Henry Harrison, M.B., B.O., B.A.Cantab., of a son.

**WALKER.**—On August 9th, at Willford Lodge, Esher, the wife of Reginald F. Walker, M.R.C.S., L.R.C.P., of a son.

## Marriages.

**BULLER-COOPER.**—On August 10th, at All Saints', Margaret Street, London, W., Chas. Hy. Buller, M.D.Lond., Tottenhall, Wolverhampton, eldest son of C. H. Buller, Ashby-de-la-Zouch, to Margaret Elsie, second daughter of John Cooke, M.B., F.R.C.S., Bexhill-on-Sea.

**COFFEY-QUINN.**—On August 9th, at St. Michael's Church, Kingstown, D. J. Coffey, M.A., M.B., F.R.U.I., son of the late John Coffey, Tralee, to Maud, fifth daughter of the late Captain M. J. J. Quinn, of Aubrey, Shanganagh, co. Dublin.

**EDLESTON-WRENCH.**—On August 11th, at St. Anne's, Baslow, Derbyshire, E. Shatto C. Edleston, M.R.C.S., L.R.C.P., Nantwick, to A. E. M. (Nancy), daughter of E. M. Wrench, F.R.C.S., J.P., of Chatsworth.

**FERRY-BELL.**—On August 13th, at St. Mary Magdalene's, Enfield, Middlesex, Charles Hall Penny, M.D., of Enfield, to Kate, widow of J. J. Bell, of Gairloch, Enfield.

**THOMPSON-EUTHERFORD.**—On August 4th, at Methodist Church, Manorhamilton, J. Henry Thompson, M.B., Ch.D., Chandlers Ford, Hants, to May, eldest daughter of B. A. Eutherford, J.P., L.R.C.P. and S., Earlsfield, Manorhamilton.

## Deaths.

**BEACH.**—On August 6th, at Winchester House, Kingston Hill, Surrey Emily Dora, wife of Dr. Fletcher Beach, in her 46th year.

**RUXTON.**—On August 5th, at 4 Brighton Parade, Blackpool, John Ruxton, M.D.Aberd., Consulting Surgeon to St. Victoria Hospital, Blackpool, aged 56.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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No. 8.

## Original Communications.

### SOME POINTS IN THE OPERATIVE TREATMENT OF TUBERCULOUS DISEASE OF THE KNEE-JOINT.

By K. W. MONSARRAT, M.B., C.M., F.R.C.S.E.,  
Surgeon, the David Lewis Northern Hospital, Liverpool.

DURING the last three years of the cases of tuberculous disease of the knee-joint which I have had under observation, I have had occasion to operate on some fourteen. Of these I have been able to follow the subsequent history in eleven, and to estimate the result of the operative procedure. I wish to make these cases the subject of some remarks relative to one or two points in the operative treatment of the condition. The extent and localisation of the disease present in these cases when first seen are shown in Table I.

TABLE I.

No. of Case.	Disease present when first seen.
1	Internal condyle of the femur, internal tuberosity of the tibia, synovial membrane.
2	Internal condyle of the femur.
3	External condyle, outer tuberosity of the tibia, synovial membrane.
4	Synovial membrane, erosion of cartilage covering the femur.
5	Synovial membrane.
6	Synovial membrane.
7	Synovial membrane, fibrous capsule, and ligaments.
8	Outer tuberosity of the tibia, patella, synovial membrane, capsule, and femoral cartilage.
9	Synovial membrane, capsule, and ligaments.
10	Outer part of the lower femoral epiphysis.
11	Synovial membrane.

A summary of the table shows in three cases synovial membrane alone; in two cases synovial membrane, capsule, and ligaments; in one case synovial membrane, with ulceration of the cartilage; in two cases femoral epiphysis alone; in two cases femur, tibia, capsule, and synovial membrane; and in one case tibia, patella, synovial membrane, ulceration of femoral cartilage and capsule. In six cases the disease was primarily synovial, and in five cases it was primarily osseous. This proportion is not representative, according to some surgeons whose experience of the disease has been large. Mr. Rushton Parker, in his article in the "International Text-book of Surgery," says, "practically always the primary focus is in the bones"; Mr. W. Watson Cheyne says the primary centre occurs "probably more frequently in the bone"; Mr. A. E. Barker says, "in the very young the femur is most frequently the

starting-point, next the tibia, then the synovial membrane, lastly the patella; the older the patient the greater the probability of the synovial membrane being first affected." Whatever the actual proportion may be, it is plain that in a large number of cases arthritis is secondary to osteomyelitis. It is in connection with this that I wish to make the first point of my remarks—the great importance of the early recognition of tuberculous foci in the neighbourhood of the lower epiphysis of the femur, and the great value of early surgical interference dealing with it. In Cases 2 and 10 this was the limit of the disease when first seen, and I will briefly relate the history of each.

CASE 2.—The patient, a boy, *æt.* 3, was brought to hospital in February, 1900. In the previous September the mother noticed that the right "knee" was swollen, although the child complained only occasionally of slight pain. When examined the whole of the lower end of the femur was enlarged, particularly that part corresponding to the internal condyle. Pressure over the front of the condyle caused considerable pain. The depressions around the patella and the general outlines of the joint were normal. The diagnosis was tuberculous osteomyelitis in the lower femoral epiphysis. The limb was fixed on a Thomas's knee splint of the ordinary pattern, and the child attended the hospital as an out-patient, but irregularly, until the following November. The condition appeared to improve, for a time at any rate, and his symptoms became quiescent, but before admission in November the disease had insidiously invaded the joint. On November 29th, I performed an arthrectomy and found an irregular cavity in the internal condyle of the femur communicating with the joint, and collateral destruction of the cartilage covering the inner tuberosity of the tibia; the synovial membrane was but little affected. The bone disease was removed with the spoon, and the surface of the cavity was rubbed with liquefied carbolic acid; the synovial membrane was also removed by dissection. Two months later it was necessary again to open the joint; unhealthy granulation tissue was removed from the cavity in the internal condyle, and carbolic acid was again used. The result—fibrous ankylosis—was satisfactory. The child developed tuberculous vertebral disease later, from which he has also recovered.

CASE 10.—The patient, a boy, *æt.* 4, was admitted to hospital on June 4th, 1902. For about a month he had complained of pain in his knee, and the mother had noticed swelling in it for the same period. On admission, the lower extremity

of the right femur was enlarged, particularly the outer condyle; it was tender on handling, and the skin covering it had a glazed appearance. The child was well nourished and had a healthy appearance. I decided to temporise, and fixed the limb in plaster. By the end of three months it was evident that the disease was not quiescent, although the joint remained unaffected. I therefore decided to attack the disease in the epiphysis, and did so on September 20th. Some weeks after primary healing, I removed some unhealthy granulation tissue by reopening the wound. The present condition is satisfactory, and the joint remains sound and unaffected.

This case supplies a suitable commentary on the first. Had I in the first attacked the disease at once when it was confined to the epiphysis, the child might now have a movable instead of an ankylosed joint. I think it is sound surgery to deal with such a focus as soon as the diagnosis is clear, without any temporising or treatment by rest, and for the following two reasons:—(1) It is difficult to estimate in any given case how near to the joint the disease has encroached, and a short delay may just make the difference between escape and involvement of the joint; and (2) the focus is as a rule accessible and can be thoroughly dealt with.

The recognition of this condition of tuberculous epiphysitis is simple: the symptoms being enlargement of the femoral extremity, usually chiefly affecting the inner part, with some swelling of the overlying soft parts; complaint of dull aching pain; tenderness on handling or percussing the epiphysis, and a normal distinctness of the parapatellar depressions. Passive movement of the joint is at the same time either unattended by pain or causes this to only a slight degree. I ask the question whether treatment by rest and general hygienic measures is not attended by unfortunate results in a considerable number of cases similar to the above. The indications for early operative treatment in a tuberculous focus of this situation differ from the indications for such interference when the disease is in the neighbourhood of the upper epiphyseal line, the difference being chiefly due to anatomical considerations. The tuberculous focus in the neck of the femur can in most cases be reached only through the joint, though cases are on record where such a focus has been reached and eradicated through the great trochanter. On the other hand, the focus in the neighbourhood of the lower growing line is accessible without encroaching on the joint, and favourably situated in regard to drainage, though perhaps in most cases the latter will not be called for.

Among hospital patients it is, unfortunately, the exception to meet with these cases before the joint is infected, and Table I illustrates the fact. This, no doubt, is to some extent due to delay on the part of parents in bringing children for treatment, but also, I think, to a too great confidence in the efficacy of treatment by rest, and to the inadequate carrying out of instructions given by medical men.

Anatomically, the most important point in operating on such a case is the outline and limits of the synovial membrane. I have constructed Figs. 1 and 2 from examinations on the cadaver, which show the following points:—(1) That in extension the lateral reflexion leaves uncovered the greater part of the lateral and posterior aspect

of the femoral condyle both externally and internally; and (2) that on flexion, these aspects are almost entirely covered.

In Case 10 I gained access to the focus from the outer posterior aspect; a two-inch incision was made parallel with, and in front of, the biceps tendon downwards as far as the lower extremity of the outer condylar ridge; inwards and downwards from this incision the surface of the bone was reached to the inner side of the outer head of the gastrocnemius. In a similar case I would in future make an incision through the skin over the outer side of the condyle, and having exposed the capsule, strip this and the synovial membrane forwards; I have found on the cadaver that by this means ready access may be obtained to the outer aspect of the condyle without penetrating the synovial membrane. Inasmuch as the tuberculous focus is more commonly situated in the neighbourhood of the inner condyle, a route from the inner side will more often be called for. Mr. W. Watson Cheyne recommends a curved incision, with its convexity upwards at the junction of the condyle with the shaft; this outlines a skin flap which is turned up, and a vertical incision through the muscular fibres towards the back of the condyle exposes the capsule, which is stripped downwards. I have found on the cadaver that simple vertical incision, similar to that which I have described for the outer aspect of the joint, gives quite satisfactory access to the postero-internal aspects of the condyle. After exposing the bone, the outer compact layer may be penetrated by a gouge or a spoon, and the disease focus thoroughly scraped out. The cavity remaining should be treated with some satisfactory antiseptic, such as 1 in 500 biniodide of mercury

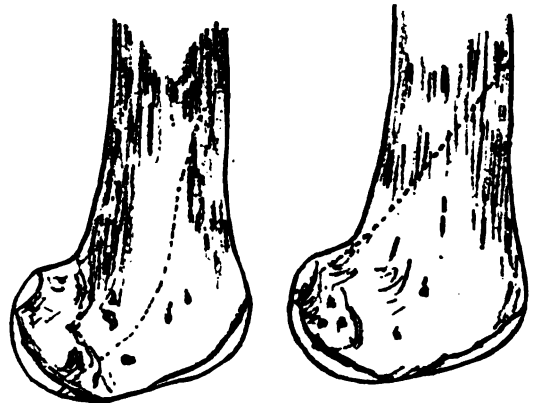


FIG. 1.

FIG. 2.

FIG. 1.—Line of reflexion of the synovial membrane in extension.

FIG. 2.—Line of reflexion of the synovial membrane in flexion.

in spirit; hæmorrhage may be checked by tight gauze packing for a few minutes, and the wound may then be entirely closed without drainage.

I wish next to refer to the results of treatment in the ten cases in which the knee-joint was opened: first, as to the recovery from the disease; and secondly, as to the subsequent functional value of the limb. The results as to recovery are shown in Table II.

By recovery I mean present freedom from local disease. In three cases in which recovery ultimately ensued I had to perform erosion twice; in one case (No. 5) the joint went to the bad altogether, owing to septic infection. The

history of this case is as follows. The primary erasion was done on February 14th, 1900, and

TABLE II.

No. of Case.	Operation.	Interval since Operation.	Ultimate Result.	Remarks.
1	Erasion.	2 yrs. & 8 mths.	Recovery.	...
2	"	(2) 2 " 3 "	"	Pott's disease; recovery.
3	"	(2) 2 " 1 mth.	"	...
4	"	2 " 1 "	"	...
5	"	(2) 2 yrs.	Amputa'n.	...
6	"	(2) 1 yr. & 10 mths.	Recovery.	...
7	"	1 " 10 "	"	...
8	Excision.	1 yr.	"	...
9	Erasion.	10 mths.	"	...
11	"	10 "	"	...

the patient was discharged with the limb in plaster on March 9th, primary healing having taken place. Unfortunately he was not brought again to the hospital until the following May 25th, and when the plaster was removed the wound was found to have reopened, and was obviously infected. In spite of a second erasion it was never afterwards clean, and I performed amputation through the middle of the thigh on April 5th, 1902, with a satisfactory result as far as his general condition is concerned. With regard to the other cases, freedom from disease has been verified by the tuberculin test in Cases 2, 4, and 11; and the others with one exception I have seen within the last few months, and there are no signs of recurrence. The exception is Case 7, which remained under observation for seven months after operation, up to which time no return of the disease had taken place. All that I wish to remark about these results is, that they show that erasion is a satisfactory operation as far as recovery from disease is concerned, even if it be found necessary to repeat it. Such repetition must be due to the overlooking of some of the disease at the first operation. It is hardly necessary to say that asepsis is all-important, and that a knee-joint the subject of mixed infection is practically doomed.

The second aspect of the result is the after-usefulness of the limb for purposes of locomotion. The present state of the limb in these cases is shown in Table III.

TABLE III.

No. of Case.	Present State of the Limb.	Remarks.
1	Ankylosis.	...
2	Fibrous ankylosis.	Flexion corrected.
3	Bony ankylosis.	No flexion.
4	Fibrous ankylosis.	Flexion corrected.
5	"	"
6	Fibrous ankylosis	No flexion.
7	"	"
8	Fibrous union.	"
9	Fibrous ankylosis.	"
11	"	Flexion corrected.

It is almost of the nature of a surgical axiom that what is to be aimed at after erasion or excision of the knee is firm ankylosis of the joint. With regard to excision, this is not only undoubtedly always the desired end, but also in most cases attained without difficulty. With regard to erasion, the question is more complicated. In the first place, after this operation, and in spite of a long subsequent immobilisation of the limb, an ankylosis, that will resist all tendencies to flexion, is not easily obtained; in fact, unless the union is one of bone to bone it must always remain in doubt. With regard to the retention of mobility

Mr. W. H. A. Jacobson says:—"The frequency with which this has been obtained and its advantage have been in my opinion much exaggerated. I have no doubt whatever that a large number of published cases will show that where movement is sought for, the risk is run of a certain degree of permanent flexion, of attacks of pain and swelling, and of the formation of troublesome sinuses. The argument against attempting to retain mobility in the joint is based, therefore, on two grounds: first, *the risk of permanent flexion*; and, second, *the risk of recurrent disease*; and if these two risks can be avoided, it may conceivably be justifiable to endeavour to obtain a functioning joint."

With regard to the question of flexion, I may compare Cases 6 and 9 with Cases 2, 4 and 11. In the one group there was never from beginning to end any tendency to flexion; in the second, flexion occurred and had to be corrected. In the first group I erased the joint by transection of the patella, with reunion of the fragments; in the second, I opened the joint by dividing the ligamentum patellæ. From this comparison and on general grounds I believe that flexion is always likely to occur when the integrity of the extensor is interfered with, and can be largely discounted by leaving this intact. If the extensor is thrown out of action the muscular balance is disturbed, and the hamstrings and the gastrocnemius are given unnatural advantage, the only resistance to flexion being the insecure scar tissue uniting the severed portions of the patellar ligament. Transection of the patella avoids this, provided firm bony union is obtained, and another method which also avoids it is Kocher's—*i.e.*, incision of the capsule on each side of and close to the patella, and division of the patellar attachments of the vasti. Transection of the patella affords ready access to all parts of the joint, and is only open to the objection that it introduces the complication of a transverse fracture, which, if bony union is not primarily obtained, damages the extensor to as great an extent as section of the ligament.

Kocher's method I have performed only on the cadaver. I have found it very difficult to obtain by it satisfactory access to the tibial surface and the posterior synovial recesses. I wish to direct attention to a method of exposing the joint which I think combines the advantages of giving free access to every part and of leaving the extensor entirely intact. A long median incision is made, commencing half an inch below the tubercle of the tibia and reaching upwards to about three inches above the upper border of the patella. (Fig. 3.) This exposes the quadriceps expansion, the patella, and the ligamentum patellæ; the ligamentum patellæ is then split exactly in the middle line, the periosteum of the patella is incised in the same direction, and the extensor aponeurosis is incised to the full extent of the skin incision, the muscular fibres beneath it being separated with the handle of the scalpel. We then have a long incision commencing two inches above the patella, which divides the quadriceps, the periosteum, and the ligament. The patella is then sawn through in the same direction and the joint is thus opened. The upper part of the incision is deepened with scissors so that the whole of the suprapatellar pouch is opened up and the quadriceps is split well above it. Perfect access to

the upper limits of the synovial membrane is thus obtained. When this upper part has been dealt with the lateral pouches are readily cleared, after which the joint must be flexed, and at the same time each half of the bisected extensor, patella, and ligament is retracted laterally until the halves of the patella lie outside the line of the



FIG. 3.—Showing median incision.

femoral condyles (Figs. 4 and 5); the tibial surface and the posterior synovial reflexion are thus exhibited, and dealt with as may be required. When all disease has been removed, the joint is again extended and the halves of the patella fall naturally together and may be fixed with a single wire suture. Continuous sutures above and below the patella bring together the halves of the quadriceps, and the ligament. I think that this procedure fulfils the requirements I have laid down—*i.e.*, free access to the joint and preservation of the extensor.

By preserving the extensor opposition to the hamstrings and gastrocnemius I think that we can discount the first objection to an attempt to retain mobility—the tendency to permanent flexion. The second objection above noted was the risk of recurrent disease. Now, it is, of course, necessary to keep the joint fixed after erosion as long as there is any doubt as to complete recovery from the disease. We are able to judge of this early and accurately by the use of the tuberculin test. I employed this test in Cases 2, 4, and 11 to determine the absence of disease before forcibly straightening the joint; in each no reaction was obtained, and I broke down the adhesions knowing that I was running no risk of setting up recurrence of the disease process. This test might also be used in cases where the retention of mobility was in question, and by its use I think the danger of recurrent disease, the second objection, could



FIG. 4.—Showing patella bisected.



FIG. 5.—Showing the knee-joint flexed and the femoral condyles exposed.



also be discounted. I do not wish to go further than this in discussing the question of attempting to obtain a movable joint after erosion, and, to recapitulate what I have said, such attempts should be confined to cases where the extensor is intact, and where the tuberculin test does not produce reaction, and, in the third place, where the possibility of obtaining a useful joint has not been excluded by removal of the crucial ligaments and joint capsule. Supposing these structures have been severed, and supposing for other reasons that the question of attempting to retain mobility is answered in the negative, how, after erosion, is firm union to be obtained? In a case in which at the operation it is clear that ankylosis is desirable, the joint cartilages should be removed and exposed bone should be brought into apposition with exposed bone, a thin slice off each femoral condyle and the upper tibial surface ensuring that this apposition is sufficient.

Lastly, a word as to indications for operative interference. (1) Cases of tuberculous foci in the neighbourhood of the lower epiphysis of the femur should be operated on as soon as the diagnosis is established. (2) Cases of joint disease by extension from the femur should be operated upon as soon as possible if this extension is recent, and if not recent, then when the disease does not definitely retrograde after about two months' fixation of the joint. (3) Cases of primary synovial disease should be operated on when, after about three months of rest, no distinct improvement has taken place.

*Note.*—Since writing this paper I have heard that the patient in Case 10 has had recurrence of the disease, but to what extent and in what situation I am unable to state.

#### NOTES ON

### THE KLOSOWSKI ANTIMONY POISONING CASE. (a)

By DR. F. J. WALDO.

Coroner for the City of London, and Southwark.

ANTIMONY has been used as the agency for various famous murder cases. Often by medical men—as Pritchard and Palmer—or by persons who have had a semi-medical training. Severino Klosowski, *alias* George Chapman, was a Pole who had passed several years as a hospital attendant. He deserted his wife and afterwards as a publican lived successively with three women, who passed as his wives, and who died one after the other. The last was Maud Marsh, who lived with Chapman (Klosowski) for a year before her death. She became ill, was treated for a time at Guy's Hospital and afterwards at the public-house where she lived with Chapman, under the care of a local surgeon. On October 21st, deceased's mother called her own family attendant from Croydon in consultation. The second medical man, on his way home, suspected poisoning by arsenic, and next day, hearing of the death of Maud Marsh, telegraphed his suspicions to the local medical attendant. The last-mentioned, after receipt of the telegram, held a post-mortem examination on the body of deceased and removed part of the viscera, in which a quantity of antimony was found on chemical analysis. Subsequent re-examination and analysis on my order as Coroner, by Sir Thomas

Stevenson, discovered  $7\frac{1}{2}$  grains of metallic antimony, equivalent to  $20\frac{1}{2}$  grains of tartar emetic in body generally, and particularly in intestines. It was shown that Klosowski frequently administered food and medicine to deceased with his own hands, and that such administration was followed by sickness and diarrhoea. Prisoner was also proved by an entry in the Poisons Book to have purchased an ounce of tartar emetic at Hastings in 1897. Exhumation of the two women who had died previously revealed the remarkable preservation of bodies characteristic of antimony poisoning, though one had been buried five years and the other about eighteen months. In each case Sir Thomas Stevenson recovered large quantities of the metal mentioned. The death of the first victim was wrongly attributed to intestinal obstruction, and that of the second to lung consumption. Chapman obtained £700 from the first of his three victims, but no adequate motive is discoverable in the other two cases.

Points to be noted: Of three deaths, two were unsuspected, the third vaguely at the last moment. Symptoms of antimony poisoning simulate various diseases. Chemists' Poison Register sometimes affords valuable evidence. In all cases of suspected poisoning it is open to medical men to ask advice of the Coroner. Such application should be made invariably by letter and not by word of mouth. Many cases of poisoning generally would be detected were the medical attendant to insist (1) on removal of patient to fresh quarters, and (2) to analyse the excretions and secretions of patient. Common law duty of *all* those about anyone dying under suspicious circumstances to report death at once to Coroner whilst body is fresh and *in situ*, not generally known by the public, and disregarded in present case by the local medical attendant.

Offence not a statutory one and not indictable.

#### Paris Clinical Lectures.

### ABDOMINAL ABSCESSSES AS AN EARLY SYMPTOM OF INTESTINAL CANCER.

By DR. TUFFIER,

Surgeon to the Paris Hospitals.

ALTHOUGH the evolution of intestinal cancer is now well established from the anatomico-pathological point of view, it remains in many respects mysterious and obscure in its clinical aspects. When we get the complete symptomatology, *i.e.*, when we have a patient upwards of fifty years of age who complains of alternating attacks of diarrhoea and constipation, or, it may be, merely of steadily progressive constipation, who gives a history of blood mixed with the motions or of melæna, whose abdomen gradually becomes more and more distended, and, lastly, when, on palpation, we make out the presence of a tumour in the region of the left angle of the colon or the sigmoid flexure, the diagnosis is easy.

But it is exceptional for all these signs and symptoms to present themselves together, and, in particular, all trace of tumour formation may be conspicuously absent. It is common knowledge that one variety of intestinal cancer takes the form of a thick, hard band or ring involving exclusively the intestinal wall, which it gradually contracts, thus reducing the lumen of the canal, though absolutely inaccessible to physical examination. In even more obscure cases the history of the patient's antecedents may reveal neither hæmorrhage nor alternations of constipation and

(a) Abstract of Paper read in State Medicine Section, British Medical Association at Oxford, July 27th, 1904.

diarrhoea. At most there exists some degree of obstinate constipation and it may be that only on closely questioning the patient do we obtain an account of comparatively mild attacks of intestinal obstruction; in short, the condition of things is first revealed by an attack of acute intestinal obstruction. I have seen numbers of these ill-defined cases, and in view of the numerous errors of diagnosis of which I was guilty in my early years, I have come to the conclusion, in patients above fifty years of age, to adopt a conventional limit—all acute intestinal obstruction is the result of intestinal cancer. Though this law may not be strictly accurate, it is clinically trustworthy, and if we apply it to all cases we shall certainly be right in ninety out of a hundred.

To-day I should like to call your attention to a mode of onset less frequently met with, more insidious and consequently less familiar to you. To enable you to judge of its clinical importance, I will relate the history of a patient whom you saw in our wards some months since. The man, æt. 54, was first admitted in May, 1903, for some trouble in the right iliac fossa. Six weeks prior to his admission, while still apparently in perfect health, he noticed some slight pain in the lower right abdomen. He went on working, thinking that it was merely a strain, but in the course of the next few days the pain increased in severity and ultimately obliged him to relinquish work. It was then that he came to see us. I discovered a circumscribed tumour in the iliac fossa reaching down to the pubic arch, and half-way to the false ribs above, extending laterally to within three fingers' breadth of the linea alba. The tumour was fixed on its base, was closely adherent to the iliac aponeurosis, but did not involve the skin, which was normal. Its surface was smooth and regular; it was hard and rather painful on manipulation without obvious fluctuation; in short, we evidently had to deal with a subacute abscess in the iliac fossa. The digestive functions had given no trouble before the first attack of pain, but since that time there had been occasional vomiting after meals. There had never been any hæmatemesis, melæna or marked constipation. The urine was normal, and the patient, a strong, robust man, had only begun to lose flesh within the last few weeks.

Our diagnosis, then, was that of subacute abscess of the iliac fossa, and as such suppurative lesions are almost always of appendicular origin it hardly seemed worth while discussing the probable upshot of the trouble. Nevertheless I had the blood examined, with the following result:—Red corpuscles, 4,154,000; white corpuscles, 10,710; hæmoglobin, 75 per cent. The leucocytes comprised 71 per cent. polynuclear; large and medium mononuclear 19.5 per cent.; lymphocytes, 8 per cent.; eosinophile cells, 1.5 per cent. These figures did not point conclusively to deep suppuration, but it would be a mistake to suppose that the differential diagnosis between suppuration and new growth in the iliac fossa is always easy. In a former lecture (*La Semaine Médicale*, 1901, p. 209), I showed you what valuable assistance hæmatology can be made to yield in doubtful cases where the chronic evolution of the lesion leaves it open to question whether we are dealing with an abscess or with a new growth.

In May, 1903, I opened the abdomen by an incision parallel to and above the pubic arch. The abdominal walls were somewhat œdematous and infiltrated, and deep down in the iliac fossa I came upon an enormous abscess filled with thick, viscid pus. The walls of the abscess cavity were thickened like those of a chronic abscess, but nowhere could I make out any special induration of a kind to raise the suspicion of the existence of a malignant growth. I carefully avoided looking for the appendix and simply provided for free drainage. In the course of several weeks all that remained was a small fistulous tract. The patient's general condition had greatly improved, and he was discharged. I may add that during his stay in the

hospital, and the following five months, he suffered from no digestive disturbance of any kind.

In October, five months after the operation, he came back, and, to my surprise, I found the right side occupied by a smooth, hard tumour, the size of the fist, adherent to the deep tissues. The orifice of the fistula had degenerated into two ulcers with irregular granulating margins resembling epithelioma, and on microscopical examination this diagnosis was confirmed. On introducing a sound through the sinus it passed down to a spongy, friable mass, bleeding readily. The situation of the growth, the good general condition of the patient and the absence of any digestive disturbances induced me to attempt its removal.

On October 14th I carried out the following operation: Having first of all applied the actual cautery to the ulcers to destroy and sterilise the granulations, I shut off the fistulous tract by means of a subcutaneous suture. I then made two elliptical incisions enclosing the ulcerating region; I drew outside the adherent mass as a whole and dissected it from the neighbouring structures. Below, I carefully isolated the tumour, which comprised the cæcum, the omentum, and a loop of small intestine. Adhesions to the femoral artery and vein and to sundry large glands obliged me to dissect off these vessels. I isolated and resected the diseased structures, including the cæcum, to within two fingers' breadth of the ileo-cæcal valve, and on the other side I removed six inches of small intestine. I sealed up the divided intestinal ends of the colon and ileum, and performed lateral anastomosis of the small intestine with the colon just above the blind ends. The subsequent course was uneventful, and the patient was still in good health four months after the last operation.

This is a very good example of the occurrence of what was apparently an ordinary abscess of the iliac fossa, which appeared to be due to subacute appendicitis, but which, in reality, was the first manifestation of cancer of the intestine. Alongside this first case, which, being one of cancer of the cæcum, a somewhat special form of cancer, may not be thought to prove my point, I will now relate two others, the clinical history of which presents a remarkable similarity.

On October 10th, 1901, I was called to see a stout, healthy woman, æt. 67, who had been operated upon two years previously for a unilocular cyst of the ovary. Quite recently her alarm was excited by the gradual development of a tumour in the right lumbar region, as to the nature of which opinions were divided. In two months the tumour had attained the size of a foetal head; it was rounded, smooth, adherent to the abdominal wall behind, and passed upwards beneath the false ribs below the liver, reaching below to the middle of the iliac fossa. Slightly tender on palpation, it was not connected with the liver; it was resonant in front and partially fixed, its movements following those of the posterior abdominal wall. Since the tumour had made its appearance the patient had lost her appetite, and had become somewhat thinner. Her evening temperature was 98.8° F. It had been thought to be an inflamed gall-bladder or a tumour of the liver or the kidney. Personally I inclined to the view that it was a case of subacute perinephritic abscess, though the origin of such an abscess left me in doubt, for I could find nothing in the patient's antecedents to suggest renal, hepatic, or even intestinal infection. The hæmatological examination on October 17th gave 3,900,000 red corpuscles, and 11,470 white, including 89 per cent. polynuclear cells; 3 per cent. large mononuclear; 4 per cent. myelocytes, and 3 per cent. eosinophile cells; a second examination, 3,627,000 red, 19,212 white, with 81 per cent. polynuclear, 10 per cent. small mononuclear, 10 per cent. large mononuclear, and 6 per cent. eosinophile cells. A third and last enumeration gave 3,813,000 red, and 15,941 white corpuscles, with 85 per cent. polynuclear; 2 per cent. small mononuclear, 6.5 per cent. large mononuclear, 5 per cent. myelocytes, and 1.5 eosinophile cells.

These figures were therefore in favour of the diagnosis of a neoplasm, but I adhered to my original diagnosis, and proposed evacuation of the abscess through the lumbar region. This I proceeded to carry out on October 24th, giving exit through the perirenal regions to a large quantity of rather foetid pus. Examination of the walls of the cavity revealed the presence of pronounced induration on the anterior wall, but not greater than one meets with in the walls of certain abscess cavities of slow formation. It was drained, and in a few weeks all that remained was a fistulous tract the size of the thumb, running from above downwards. The discharge, however, remained foetid, though it contained no trace of faecal matter. On introducing the finger one came upon a hard, irregular mass of woody consistence, which bled readily on being touched. I again had the blood examined, and found 3,606,230 red corpuscles and 11,439 white—viz., 85 per cent. polynuclear, 1 per cent. small mononuclear, 3 per cent. large mononuclear, 5 per cent. intermediate, 3 per cent. myelocytes, and 1 per cent. eosinophile cells. The anæmia had therefore persisted and the leucocytosis remained, whereupon we arrived at the conclusion that it was a case of cancer. Before long faecal matter began to come away in the discharge, and a few weeks later large cancerous granulations, recognised as such under the microscope, sprouted from the bottom of the wound, the patient dying four months after with a large malignant growth of the large intestine.

In this case also the first symptom of the existence of an intestinal neoplasm was a pericolic suppuration, the intestinal origin whereof there was nothing to suggest. The blood examination alone threw some doubt on the diagnosis of abscess.

The most noteworthy case of pericolic abscess of cancerous origin is that of a man, æt. 47, who eighteen months ago was in our wards. He was an ex-soldier, who had suffered from dysentery in China, and the disease had persisted as chronic enteritis. He came complaining of a large swelling in the supra-umbilical region, the exact nature of which was very difficult to make out. There was nothing in his history to suggest any intestinal lesion, for his intestinal functions were in the same state as they had been for years past; in short, he had suffered from neither constipation nor hæmorrhage. The swelling in question had been of comparatively rapid formation, and was accompanied by rather severe attacks of pain, the temperature, however, not having shown any marked rise. The tumour occupied the epigastric and umbilical regions, reaching two fingers' breadth below the navel. It was about twice the size of the fist. The skin over it was healthy, but the tumour was adherent to the structures below it, its surface somewhat irregular; it was of putty-like rather than woody consistence, it was dull on percussion, a zone of resonance separating the dull area from the liver.

The patient's antecedents, the persistence of the colitis for upwards of twenty years, the rapidity with which the swelling has developed, the pain and the absence of any pressure symptoms led me to conclude in favour of its being a pericolic abscess situated in the transverse colon, due in all probability to dysenteric ulceration of old standing. The examination of the blood gave 3,990,000 red, and 12,652 white corpuscles, including 73 per cent. polynuclear, 16.3 large and small mononuclear, 10 per cent. lymphocytes, and 7 per cent. eosinophile cells.

On November 7th, 1902, I cut down on the abscess through a median incision four fingers' breadth long, starting from the umbilicus. The omentum was adherent to the abdominal wall, and behind it I cut through some lardaceous tissue which led me into a cavity the size of an orange, filled with grumous pus free from fœtor. The walls of the abscess cavity were thick and indurated. I drained, and a few days later traces of faecal matter appeared in the discharge, a circumstance which excited no surprise, since it was quite possible that an intestinal ulcer had opened into the cavity. He was placed on a dry diet, and the faecal

discharge ceased, his general condition improved, and he appeared to be on the road to recovery. He went on all right for three months, although the fistulous tract persisted, when once more faecal matter began to come away, along with a blood-stained, foetid discharge, and though there was no digestive disturbance the patient began to lose flesh. At the same time we noted the formation of a tumour hard to the touch and irregular in outline, which rapidly increased in size. Unhealthy-looking granulations projected through the wound, the patient became cachectic, and died on February 22nd, 1903.

*Post-mortem.*—Cancer of the transverse colon was found which had involved the omentum, the stomach and the liver.

It was, as you see, a third instance of pericolic abscess that had formed round a neoplasm of the large intestine. The diagnosis presented peculiar difficulty in this case because the long-standing chronic dysentery led one to suspect the source of the trouble to be an intestinal ulcer. In this case also there was complete absence of any digestive disturbances, and the first indication was the formation of a peri-intestinal collection of pus.

It is highly probable that the three cases I have related are by no means exceptional, and that now that I have called attention thereto, many other instances may be brought forward. The mode of progression in these cases is not difficult to imagine. The peri-intestinal suppuration starts in a breaking-down gland consequent upon epithelioma of the intestine, a form of glandular inflammation, due to mixed infection, similar to that often met with in connection with cancer of the tongue, even at a period when the cancerous lesion is of small dimensions. The comparison is the more justifiable since intestinal like buccal ulcers are in contact with a highly infective secretion, so that the intestinal lymphatics may convey not only the cancerous elements, but also the pyogenic germs. The suppuration, moreover, can be explained by the anatomical form of these neoplasms. We are aware, as a matter of fact, that in certain forms of epithelioma there is a tendency to early perforation. If the perforation takes place on a part of the intestinal wall covered by peritoneum, adhesions form, but if on a part uncovered by peritoneum, suppuration is set up in the connective tissue and an abscess results. The first hypothesis agrees with observed facts, for the passage of faecal matter takes place only some days or weeks after the evacuation of the abscess contents. This fact suggests that the perforation of the intestine occurs later.

The exact mode of production of these collections of pus, however, is a matter of secondary interest. The point to which I wish more particularly to call attention is that certain peri-intestinal suppuration of uncertain origin, even in the absence of any digestive disturbance, should raise in our minds the possibility of their being due to the presence of a cancerous lesion of the intestinal mucosa.

## The Seventh International Congress of Otolology.

BORDEAUX, AUGUST 1ST TO AUGUST 4TH.

PRESIDENT, DR. MOURF.

At the opening meeting the President delivered an address upon the history of otology in France, commencing with the work of Duverney in the seventeenth century.

THE CHOICE OF A SIMPLE AND PRACTICAL ACOUOMETRIC FORMULA.

A joint report upon this subject was presented by Politzer, Delsaux, and Gradenigo, who form a permanent committee, meeting once a year, for studying the points still undecided. Quix (Utrecht), Fpanse (Dresden), Trêtrôp (Anvers) and Bonnier (Paris) read papers on the same subject.

## THE DIAGNOSIS AND TREATMENT OF SUPPURATION OF THE LABYRINTH.

Three co-reporters. (1) Brieger (Breslau) said that the radical mastoid operation might lead to the spontaneous cure of a suppuration in the labyrinth; or, on the other hand, the suppuration, latent before, might become active after the operation and provoke a fatal meningitis. Operation on the labyrinth is indicated in acute otitis media, when, with collapse or fever, there is serious disturbance of equilibrium, nystagmus, and rapidly progressive deafness; or when, with labyrinthine symptoms, signs of meningitis appear. In chronic cases there are various indications, which the author gives at length, as well as a description of the modes of procedure. (2) Von Stein (Moscow) distinguishes para-labyrinthitis, peri-labyrinthitis, endo-labyrinthitis, and panta-labyrinthitis, according as the bony capsule, the peri-lymphatic space, the endo-lymphatic space, or all these structures together are affected. (3) Dundas Grant spoke of the relations of labyrinthitis to meningitis and to cerebellar abscess. He dealt with prophylaxis, the early detection of labyrinthine trouble, and the indications for operation. Politzer (Vienna) described the pathological changes in the labyrinth which are produced in serious suppurations of the middle ear, and showed preparations. Panse (Dresden) showed preparations and original drawings of ten cases of labyrinthine suppuration. Escat (Toulouse) reported three cases of necrosis of the cochlea with spontaneous elimination. Two of these occurred in the course of chronic otorrhœa, the third was of special interest. A young man, æt. 21, during an attack of scarlatina, presented the signs of acute labyrinthitis, while the tympanic cavity remained intact. The latter was affected later with a secondary suppuration, and the whole of the necrosed cochlea came away. The necrosis was probably due to septic thrombosis of the cochlear artery. Moure (Bordeaux) showed by means of the cinematograph the characteristic staggering gait of a number of patients with affections of the labyrinth.

## THE TECHNIQUE OF THE OPENING AND THE AFTER-TREATMENT OF OTOGENOUS CEREBRAL ABSCESS.

Three co-reporters. (1) Knapp (New York) showed the encephaloscope, recently devised by Whiting (New York), a useful instrument for examining the walls of the abscess-cavity. He advised cautious irrigation, if the flow of pus is abundant. When the opening gapes there is no need of a drainage-tube. Hernia cerebri is caused by a secondary abscess. Secondary abscesses inside the cranium are not rare, they cause aggravation of all the symptoms and death by encephalitis or meningitis. (2) Schmiegelow (Copenhagen) advises that the operation should be planned so as to make it possible to explore both cerebrum and cerebellum, and should commence by a free opening of the middle ear. The anæsthetic should be given with great caution, owing to the risk of failure of respiration. (3) Botey (Barcelona): The operation should always be commenced by an exploration of the mastoid and tympanum, passing thence to the intra-cranial cavity. He advises that, as a rule, the brain should be punctured through the intact dura before incising the latter, so as to make certain of the existence of an abscess; for, when the dura has been incised by a knife the brain and meninges are much more exposed to infection. He condemns irrigation of the abscess cavity, and advises drainage by means of several small tubes. Gradenigo (Turin) described a special form of intra-cranial complication with the following association of symptoms:—Acute otitis media, severe pain in the corresponding side of the head, especially in the temporo-parietal region, and paralysis or paresis of the external rectus on the same side, without other ocular disturbance. He has himself observed six cases. The symptoms are due to a circumscribed focus of leptomeningitis. MacEwen (Glasgow): Besides treating the aural and cerebral foci, it is necessary to attend to the morbid tract leading from the one to the other. Neglect of this precaution is a frequent cause of recurrences. The instruments for exploring the brain

should be used with great gentleness. If after having incised the dura, no adhesions are found in the sub-arachnoid space, the author leaves a carbolic dressing in place for twenty-four hours, and then incises the brain; by that time adhesions will have formed. As an anæsthetic, chloroform is preferable to ether, which causes œdema of the brain. After the incision, which is made as free as possible, the author irrigates very gently; he uses no drain at all or, at the most, sometimes a strand of gauze.

Among the numerous communications presented were the following:—

Lermoyez and Bellin (Paris): "A Contribution to the Surgical Cure of Acute Otogenous Meningitis."—Two cases of recovery from general meningitis arising from the ear. The first, a girl, æt. 19, with old otorrhœa, after a month of vague general symptoms suddenly developed intense headache, stiffness of the neck, facial paralysis, and Koernig's sign. Lumbar puncture showed lymphocytes, 58 per cent., polynuclear cells, 40 per cent. A large operation upon the petrous bone was performed; the labyrinthine wall was carious, the dura covered with granulations. The following day the temperature fell to normal. Koernig's sign persisted for several days. A week later lumbar puncture showed very abundant lymphocytes, but hardly 1 per cent. of polynuclear cells. Two weeks later the spinal fluid was normal. The local cure was slow on account of a large sequestrum of the labyrinth. Eighteen months after the cure is perfect.

In the second case, a girl, æt. 19, with old otorrhœa, developed Bezold's mastoiditis after a chill. At the operation an eburnated mastoid was found full of thick pus; the dura mater was healthy. Ten days later the signs of meningitis suddenly appeared. Intense headache, stiff neck, vomiting, and fever. Lumbar puncture gave a turbid liquid with intense polynucleosis. The dura was then incised, no pus was found in the meninges, and exploration of the temporal lobe was fruitless. The symptoms of meningitis then disappeared, but there was a relapse a week later. A lumbar puncture was followed by improvement. A second relapse, with inequality of the pupils, occurred after another week. But the cerebro-spinal fluid became normal. From this time the general condition improved, the fever fell gradually, and the headache became intermittent, but the pupils remained unequal for a long time. A sequestrum of the labyrinth delayed the local healing, but eight months later the patient was quite well.

Delie (Yprès): "Tobacco and Audition."—A report of twelve cases with nerve-deafness, tinnitus, and vertigo caused by the abuse of tobacco.

Broeckeaert (Ghent): "Upon Injections of Paraffin while Cold."—The author showed a new and convenient syringe.

Möller (Copenhagen): "The Report of an Autopsy in a Case of Oto-sclerosis."

Molinié (Marseilles): "Two Cases of Occlusion of the Pharyngeal Orifice of the Eustachian Tubes," apparently caused by a rash use of the galvano-cautery.

Cauzard (Paris): "A Case of Caries of both Petrous Bones," in which sequestra came away from the naso-pharynx.

Botey, R. (Barcelona): "The Prevention of Stenosis of the Meatus after Radical Operations on the Ear."—None of the plans hitherto proposed for preventing this complication give a certain result. The author makes an incision through the antero-superior part of the membranous meatus as far as the auricle, passing between the superior edge of the tragus and the root of the helix, where the cartilage is wanting. At the conclusion of the operation a metallic cone, slightly flattened, is introduced and left in place for five or six weeks. The dressing for the deeper parts is introduced through the cone. The results of this plan have been uniformly good; the patients remain with a very large meatus almost concealed by the tragus.

Mignon (Nice): "A Grave Form of Eczema of the Ear," &c.

A museum of pathological specimens, models, and instruments was arranged in one of the rooms at the School of Medicine, where the Congress was held.

A proposal that in future the Congress should be held at intervals of three instead of four years was not carried. The next Congress will, therefore, be held at Buda-Pest in 1908.

During the Congress the President gave a delightful garden-party and banquet to the members at his charming chateau at Carbon Blanc. The delegates were also hospitably entertained by the French Society of Otolaryngology and the French Committee of Organisation, by the Mayor of Bordeaux and by the United Syndicates of the Wine Growers of the Gironde.

CHICHELE NOURSE.

## British Health Resorts.

### VII.—KYNANCE (CORNWALL).

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

THE Lizard district, Cornwall's almost island promontory, has long been known to the adventurous explorer, the enthusiastic naturalist, and the Nature-loving artist, but it can hardly claim conspicuous distinction as a health station. It consists of a tableland elevated a few hundred feet above the sea, very bald and treeless, and without hills to break its uniformity.

The uplands of the peninsula, while offering much of interest to the botanist and tourist, afford but little that is suited to the needs of the invalid. The district is bracing, but the lack of protection from winds, especially those from the east, limits its usefulness as a resort for the health seeker, and, indeed, renders it unsuitable for many cases except during the summer.

"The Lizard may be regarded as a bracing, healthy, and interesting resort for the summer and early autumn, but is not suited for invalids in the winter and early spring." (a)

The coastline of the Lizard is, however, peculiarly fascinating, and many of its sheltered bays and but little-known coves afford protection and furnish climatic conditions well suited to the needs of the feeble. The district at present, it is true, is more adapted to the requirements of the active holiday maker desirous of using wisely a brief period of respite from the stress and strain of daily routine than to the more elaborate and carefully formulated demands of the invalid. The prophylactic value of a judiciously selected holiday resort is now being recognised, and medical practitioners would do well to acquaint themselves with the merits of the Lizard's much indented sea-line, both for themselves and those who may be guided by their advice.

We have visited much of the coast of this district, and can fully endorse the opinion of Mrs. Craik: "For grandeur, for solitariness, and for the sense of immensity which says 'Be still!' to all worldly care, there is no coast like the Cornish coast, and no sea like the Cornish sea." And certainly among the many charming coves of the Lizard, Kynance has first place. The late Lord Leighton, conscious of the psychical influence of the spot, wrote: "Kynance is perfectly unique; it is a lovely picture, and the finest cove in the kingdom."

This is not the place to describe the fascination of colour afforded by sky, sea, sand, rocks, and verdured cliffs. With the ebb and flow of tide an ever varying round of charms is offered to the naturalist and lover of Nature. At low water the wonderful caves in the many hued serpentine furnish endless delights for the explorer. The visitor to Kynance Cove will find no aggressive hydro, vulgar hotel, or commonplace lodging-houses, but a simple, primitive existence and strict hygienically directed life, free from the trammels of fashionable society and the infinite irritations of a popular resort, which may be enjoyed at the unsophisticated little cottage boarding-house kept by the kindly local serpentine worker.

(a) "The Climates and Baths of Great Britain; being the Report of a Committee of the Royal Medical and Chirurgical Society of London." Vol. I. London. 1895.

It is not for us here to describe the many merits of Kynance, but rather to draw attention to its many advantages as an altogether unspoilt natural retreat for the overworked in body and the overwrought in mind. It is far removed from the rush of present-day so-called civilisation and sheltered from much of Nature's inclemency. It is freely exposed to vitalising sunlight and health-bearing sea breezes, and offers excellent opportunities for bathing. The naturalist will find much material and unceasing opportunities for study. We have visited Kynance in the spring and found it an ideal spot, and we learn from those well fitted to express an opinion that even in the winter it is comparatively sheltered, warm, and allows of the conduct of an enjoyable open-air life. The inaccessibility of Kynance is not the least of its advantages, and yet by a little careful arrangement even an invalid may travel thither with a minimum of discomfort.

The Great Western Railway now run fast and in every way convenient trains to Helston, which is 32½ miles from Paddington, in about seven hours. From Helston motor cars and coaches travel to Lizard Church Town, which is only an easy walking distance from Kynance for the vigorous. Delicate visitors should drive by carriage from Helston to Kynance, a distance of about ten miles. Kynance may also be reached by invalids staying at Falmouth by an interesting drive of some twenty miles.

## EGYPT AS A HEALTH RESORT.

UPPER EGYPT (continued from page 16).

[BY OUR SPECIAL TRAVELLING CORRESPONDENT.]

CAIRO might well be described as the Paris of the East. The city is full of avenues, gardens, promenades, cafés, &c. It also possesses some of the most attractive hotels, such as the Ghezireh Palace Hotel (the ancient palace of that luxurious prince, Ismail Pasha), Shepheard's Hotel, and Hôtel Savoy. They are well situated, and adapted with the necessaries for convalescents and those needing the open-air treatment. As a medical man I would specially recommend the Ghezireh Palace Hotel, with its beautiful landscape, situated out of the town, and encircled by lovely gardens. The luxurious comforts of these hotels are, broadly speaking, attainable only by well-to-do people, but for those whose resources are limited, similar accommodation can be obtained at the Pension Tewfik, Pension Margosches, or by inserting a notice in the *Egyptian Gazette*, some time before leaving home, requesting board and lodging with a private family, with terms, &c., in the usual way.

Cairo has some splendid hospitals—the Kasr-el-Aini, having at its head the well-known surgeon of the Levant, Dr. Milton, and to which a medical college is attached. Though the hospital is of considerable size and fitted with the latest modern improvements, it is chiefly for the use of Egyptians, and the nursing being in the hands of the latter, renders it unsuitable for Europeans requiring proper nursing. The smaller English hospital is very neatly kept, with good sanitation and under the guidance of an excellent physician, Dr. Murison. The Deaconess' or Prussian hospital is a pretty little building attended by Dr. Wildt (German) and Dr. Sandwith (English).

About a hundred yards distance from Shepheard's Hotel there exists a bathing establishment, having the latest and most improved requirements of hydro- and electro-therapeutic treatment, with massage, &c., and under the direct supervision of German specialists, who are annually brought out to Egypt by the proprietors during the autumn and winter seasons for the purpose of superintending the establishment; and on the whole it may be said of Cairo, coupled with its climate, temperature during autumn and winter, and the mode of living and the picturesque and kaleidoscopic sight of the different nationalities and Eastern manners, that it constitutes for convalescents and those suffering from chest

diseases, as well as for rheumatic and gouty subjects, a most invigorating and attractive health resort. With regard to sanitation, much has yet to be accomplished. Cairo, in those quarters occupied by Arabs, is filthy and unhealthy, but Cairo, the centre, is clean and healthy. Anyone desiring medical attendance can safely choose among the following well-known physicians and surgeons:—Dr. Milton, Dr. Foster, Dr. Toller, Dr. Murison, Dr. Sandwith, Dr. Wildt, Dr. Coumanos Pasha, and Professor Fornario. Half an hour's distance from Cairo is Helouan, with its well-known mineral spring.

Luxor is about twenty hours' run from Cairo. It contains ancient temples. There are only two hotels—the Hôtel Luxor, which generally has an English physician for the season, and Mr. George Comomilla's hotel. Excepting the antiquities there is nothing attractive here, and nothing worthy of note. The climate in summer is necessarily warm, but in winter it is dry and bracing. Life, however, is very monotonous, and there are no British residents.

ASSOUAN is a healthy little town possessing an attractive hotel (Pagnon's Hotel). There are historical ancient temples, the climate is invigorating, dry, and temperate during the winter, but exceedingly warm during the summer. Medical attendance can be obtained from the English medical officer attached to the Assouan hospital. The climate is indicated as particularly suitable for patients suffering from nervous and constitutional diseases.

WADY HALFA is about six hours' run from Assouan. There are only one or two small hotels worth mentioning. Medical attendance can be had from medical officers attending the military hospitals only by favour. The town is dull and monotonous, but the climate is temperate, healthy, and bracing, and those suffering from hepatic disorders caused by irregular living cannot choose a better place or climate for a season.

## France.

[FROM OUR OWN CORRESPONDENT.]

Paris, August 21st, 1904.

### EXPERIMENTAL TREATMENT WITH NUCLEINATE OF SODA.

NUCLEINIC acid, says Prof. Huchard, has been employed by a few physicians for gout as a solvent of uric acid, as a general tonic, and as an anti-tuberculous agent. Seeing that nucleinic acid provoked hyperleucytosis when injected into animals, he charged his house physician to try nucleinate of soda as an anti-infectious agent producing in the organism hyperphagocytosis. M. Huchard employed this in six cases in daily injections of twenty drops of a 5 per cent. solution, representing one grain of the drug. No pain or local inflammation was ever observed during the treatment, proving it to be absolutely innocuous. Of the six cases treated, three experienced no benefit from it, but the success in the remainder was very remarkable. The first of these patients had already been in the ward two months, suffering from pulmonary phthisis. A large vomica was situated in the right apex, emaciation was considerable and progressive, while the temperature rose in the evening to 103°. On July 6th, the patient had arrived at the last stage of the disease—pallor, cyanosis, hæmoptysis, dyspnoea, with all the signs of impending dissolution. As a last resort injection of nucleinate of soda was ordered. The following day, to the astonishment of all, the patient was still alive, and eight days subsequently the patient was able to take strong nourishment—eggs, beef-tea, milk, raw meat. The dyspnoea had entirely disappeared and the patient was able to get up and walk about the ward. The improvement continued each day.

The second case was a man who entered the hospital for pneumonia. This patient, who had had a cough for some time, had got thin, but nevertheless was able to continue his trade as a baker. The day before he entered the hospital he was seized with pain in the side. On examination intense dullness was found over the right apex with crepitant *râles* without wheezing. The temperature was 104°. Pneumonia of the apex of the right lung of perhaps bacillary origin was the diagnosis made. The next day the patient was plunged in stupor, in a half comatose state, answering questions put to him with difficulty. Although the pulse was good (96) the dyspnoea was intense, the face pale and drawn, eyes sunken, the weakness was extreme. An injection of caffein and another of nucleinate of soda were ordered and a stimulating mixture. After the third injection of nucleinate of soda, the symptoms began to rapidly amend, so that on the seventh day the patient was able to get up and take ordinary food.

The third and last case was that of a nurse, *æt.* 20, suffering from typhoid fever of a very grave type; in a delirious, semi-comatose state, with high temperature and profuse and fetid diarrhoea; pulse 120; congestion of both lungs, dyspnoea, intestinal hæmorrhages. After ten daily injections of nucleinate of soda the patient, in spite of her very unfavourable condition, was convalescent. It should be added that the usual treatment—caffein, ergotin and intestinal antiseptics—was continued concurrently with the injections.

Professor Huchard concludes by saying that he intends to continue the experiments with this drug, believing the treatment to be quite rational and in any case it exposed the patients to no danger.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 20th, 1904.

At the Society of Charité Physicians, Hr. König spoke on

CHOLECYSTOTOMY AND CHOLECYSTECTOMY, and showed some cases. One of the cases was of interest from the fact that it had been mistaken for a movable kidney, so that nephrorrhaphy was first performed, and afterwards the gall-bladder was opened. Violent pain came on again later, and necessitated another operation, when a stone was found in a diverticulum of the duct; the gall-bladder was now removed. The latter operation should be performed when the calculi were difficult to remove, or a tumour was present, otherwise cholecystotomy would be sufficient.

Hr. Milner spoke on

### CIRCULATORY DISTURBANCES AFTER COMPRESSION OF THE THORAX.

Such disturbances sometimes came on after severe pressure on the thorax. They were accompanied by cyanosis, œdema of the face, and especially of the eyelid, there might be even hæmorrhages into the fundus oculi. There were cases in which the blood was forced backwards out of the thorax along with reflex closure of the glottis.

At the Free Society of Surgeons, Hr. Kroner gave notes of a case of

### INTRA-PERITONEAL TORSION OF THE OMENTUM.

A patient who had a reducible inguinal hernia found one day that he could no longer replace it, and had slight abdominal pain with vomiting. The following day, however, he felt quite well. On the tenth day after this he was admitted into hospital with



irreducible hernia, but with no accompanying symptoms of incarceration. At the operation, dark-looking adherent omentum was found in the sac, although the ring was not tight enough to cause constriction. It was formed into a cord, and an extension of the operation showed that it had the cord-like character as high up as the transverse colon, and that it was several times twisted on itself. The whole omentum was bluish red, with necrotic spots in places. A length of 36 cm. was removed, and the abdomen closed, the patient doing well. The slight character of the symptoms accompanying such serious changes was remarkable. No explanation of the twisting could be made out.

Hr. Sonnenburg had been able to untwist the omentum in a recent case, and saw how it regained its normal colour as this was done. He had also noticed the slight character of the symptoms presented.

Hr. Schroeder showed some

#### FOREIGN BODIES

removed in operation. The first were foreign bodies from the vermiform appendix, among them two oxyurides vermiculares, a splinter of steel, a fragment of walnut shell, a crushed cherry-stone, the two latter in a perityphlitic abscess. Probably they were quite accidental, and had nothing to do with the disease etiologically, except, perhaps, in the case of the piece of steel. Further, a coffee-bean from the trachea, removed from a child by tracheotomy, a plate of teeth removed from the œsophagus, an iron ring a pound in weight, that a man had drawn over his penis six days before, the penis swelling very much afterwards; two Röntgen pictures of projectiles that set up no reaction, and a piece of cartilage from the knee-joint of a girl who some time before had fallen on her knees.

He also showed a man who, after a radical operation on his ear, had complete paralysis of the facial nerve as a consequence. The paralysis had, however, been materially improved by plastic transplantation of a portion of the accessory nerve.

Hr. Rinni spoke on

#### TALMA'S OPERATION FOR CIRRHOSIS OF THE LIVER.

He had performed the operation three times, but two of the patients were in a desperate condition, and died a few days afterwards; in the third case a comparatively favourable result was obtained. The patient was shown. She was admitted into hospital in November last with excessive ascites and brown discoloration of the skin. The liver dulness was small, the spleen very much enlarged. Laparotomy revealed an atrophied liver, a large, hard spleen with a strongly thickened fibrous capsule. Suture of the omentum between the peritoneum and musculature in two large pockets. The ascites quickly reformed, and then began to diminish spontaneously, and had not again returned. The general condition had improved very much, and the discoloration of the skin had disappeared. Probably congenital syphilis was the cause of the illness.

Hr. Borchartd had performed the operation in two cases of syphilitic cirrhosis of the liver, but without any benefit.

Hr. Martens related a case of

#### RENAL SURGERY.

A boy, æt. 13, had suffered from renal colic of the left side with passage of gravel and small calculi. After some time the urine became quite clear, but the pain still persisted. Catheterisation of the ureters showed that the left kidney was much less active than the other. Nephrotomy was performed in November last, when it was found that the left kidney was contracted, but there was no stone. The kidney was

sutured, but the capsule was left open in order to lessen the pressure on the kidney. Since then there had been no more pain.

In a similar case shown some time ago, the pain had ceased as in the one related.

The same speaker also related the case of a married woman, æt. 28, who had fever after separation of the placenta, with vomiting, and a painful resistance on the left side. The urine contained pus corpuscles and blood. Catheterisation of the ureters showed that both kidneys were diseased. As the case went on endocarditis developed, but after some months' illness, the patient eventually recovered.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 21st, 1904.

#### OSTEO-ARTHROPATHICA TABES VERTEBRALIS.

RUDINGER exhibited a tabetic patient to the Society for innere Medizin, with kyphosis in the three first lumbar vertebræ, and notwithstanding this morbid condition of the osseous structure, the functional activity of the cord was unimpaired by the lesion. This freedom of movement eliminated several etiological factors in the diagnosis, such as heteroplastic neoplasms in the canal itself. By this observation tumours or aneurysms of the dura mater were excluded, which might be supported by the duration of the disease, which had been under operation for at least four years, and the absence of any myelitic symptom. Then, against tuberculous spondylitis the evidence of no pain, either subjective or objective, and free functional movement in the cord excluded any other diagnosis than osteo-arthritis tabes vertebralis.

The Röntgen rays showed the sacral and lumbar bones in a normal condition with the exception of the second and third lumbar vertebræ. The second was broken on the left side, while the third was broken on the right side, thus making two wedges, bending the column sharply above and below the lesions.

#### GASTRIC ANTHRAX.

Schmidt next showed a few microscopic preparations taken from a patient who subsequently died of the disease. The patient first came under his observation nine days before the exitus. From the clinical observation he appeared to be suffering from a very severe form of general poisoning, as the abdominal symptoms were the most prominent. The epigastrium was tender and swollen, with sickness and vomiting, which led to the first diagnosis of gastritis phlegmonosa, although the possibility of anthrax was taken into account owing to the resemblance of some of the symptoms, and by reason of his trade, a cabinet-maker, which brought him into contact with the hair of animals. There was no diarrhoea or colic with the sickness that lent a strong suspicion to anthrax.

An examination bacteriologically was undertaken to confirm the diagnosis of gastritis phlegmonosa, but nothing could be found in the contents of the stomach to justify anthrax, neither could anything be found in the blood. Shortly after this the patient suddenly collapsed and died.

The post-mortem revealed a large necrotic inflammatory ulcer in the mucous membrane of the stomach, but not a single trace of an ulcer could be found in the bowel lower down. Sections of this ulcer were taken and stained by Gram's method, with the result that anthrax bacilli were found for the first time.

How the infection was carried into the stomach alone is not yet quite clear, although the patient always

blamed the eating of a sausage for bringing on the illness which, strangely enough, commenced the following day.

#### CONSTIPATION AND HYPNOTIC SUGGESTION.

At the Naturforscher, Delius proposed hypnotics for constipation. He commenced by discussing the physiology of alimentation, and said that defæcation did not depend entirely upon the stimulus of the fæcal mass in the bowel, or the innervation of the mucous membrane of the rectum. There is also a central automatic influence to be considered in addition, as the faith of the patient is always a potent factor in the gastric movements, and particularly in defæcation.

When the bowels first become sluggish we know it is due to a loss of innervation of the sympathetic. By the hypnotic suggestion the automatic movements are stimulated, and a stronger innervation wave produced along the whole alimentary tract, which, if repeated, will soon put the bowel in a normal condition. The reverse takes place in functional diarrhœa, and the deeper the hypnosis the more effectual is the remedy. He tells us that out of eighty-four cases treated in this manner, only 4 per cent. failed, 15 per cent. improved, and 79 per cent. were perfectly cured.

Schmidt said that he would rather discourage this treatment altogether. The primary disturbance of constipation is to be sought for in the motor sphere, and by careful attention to feeding all can be accomplished that Delius claims for hypnotic suggestion. For the argument of increased decomposition by bacteria, when long detained in the bowel, is without any force as the bacteria are not increased by constipation.

Naunyn thought the speaker in presenting this subject to the meeting had made a mistake, as the fæces in constipation do not increase in bacteria though long detained in the bowel, which is certainly opposed to the accepted opinion that the longer the fæces are detained in the bowel the greater will be the decomposition.

Schmidt said that he would further emphasise this fact by saying that indol and sulphuric ether are even reduced in constipation, which, he thinks, may be used up intestinal ferments.

Bäumler thought the hypnotic remedy a good one, and likely to be successful.

Fisch thought he had a better agent than hypnotism for constipation in carbonic acid baths when given in proper doses. The latest addition to this subject shows that the dosing must be gradually increased to be effectual. These baths act on the hæmatic circulation as proved by their efficacy in chlorosis, anæmia, debility, and convalescence.

Raether thought the baths may be very good in their way, but the new system was far too expensive for practical use. Each bath, according to the latest tariff, is three marks, while a Sandow only costs one mark and twenty pfennings. He thought the new system was prohibitive.

## The Operating Theatres.

### GREAT NORTHERN HOSPITAL.

**INFLAMED APPENDIX IN THE SAC OF A FEMORAL HERNIA.**—Mr. WARREN LOW operated on a married woman, æt. about 30, who had been admitted for a tender swelling in the right groin. She stated that she had had a swelling there since the birth of her last child, a year ago, but that it had not given rise to any inconvenience. Three days before admission she noticed that the swelling became tender and she vomited. The tenderness and pain in the swelling continued, but the

vomiting ceased. The bowels were opened on the night before admission by means of a laxative. On admission she was not collapsed and did not appear very ill; she had been sick since the onset of the attack, and there was no evidence of intestinal obstruction. In the region of the right femoral ring there was a tender swelling over which the skin was red and œdematous. The patient stated that there had been some attempt made at reduction by taxis. The patient was prepared for operation with the view that the hernia was an irreducible femoral hernia, with an inflamed sac. On exposing the tumour the sac of the femoral hernia was found in the usual position; on carefully incising this some foul-smelling pus escaped, which further examination proved to have arisen from a small abscess outside the apex of the appendix, which was adherent to the sac of the hernia, and in which there was a small perforation. The pus was carefully wiped away and the interior of the hernial sac disinfected before drawing down the cæcum to remove the appendix. This was effected in the usual manner by turning down a cuff of muscle and peritoneum and ligaturing the mucous and submucous coats and afterwards invaginating the stump into the cæcal wall. The sac of the hernia was then tied and removed, the external wound partly closed, a drainage-tube being left in position down to the closed sac. Mr. Warren Low said that the diagnosis in this case was that of an inflamed hernia, a condition sometimes due to injury to the sac or its contents from prolonged taxis. The diagnosis was correct but the cause of inflammation lay in the peculiar contents of the sac of the hernia—namely, the appendix vermiformis, which was undergoing an ordinary attack of appendicitis. He had often met with the appendix in the right inguinal hernia of young children, but he had never yet operated upon a case in which the appendix was in a condition of inflammation, though this complication had been found by other surgeons. It was important, he thought, in such a case to carefully cleanse the sac and the external wound before drawing down the base of the appendix in order to effect its removal as, although no adhesions had shut off the sac from the peritoneal cavity, no general infection of the latter had taken place at the time of operation. Bearing in mind the possible infection of the wound by the foul contents of the sac, no attempt at a radical cure could be made by bringing up a flap of pectineal fascia to Poupart's ligament. For a similar reason a drainage-tube was left in the external part of the wound, though it was considered safe to close the peritoneal cavity. The patient left the hospital about three weeks after operation, never having had an adverse symptom.

### ST. PETER'S HOSPITAL.

**CASE OF NEPHRO-LITHOTOMY.—LARGE CALCULUS.**—Mr. SWINFORD EDWARDS operated on a case of a man, æt. about 40, who came to the hospital complaining of right lumbar pain, with a deposit of pus in the urine, and occasional attacks of hæmaturia. He had undergone operation for stricture some years previously by Mr. Edwards. After the lapse of a few days, Mr. Edwards examined the bladder through the cystoscope under an anæsthetic. The right ureteral orifice was patent and somewhat protruding; pus was seen to be coming down the ureter. On the left side the ureteral orifice appeared normal. The bladder, which was somewhat fasciculated, was otherwise normal and contained no growth or stone. An X-ray photograph was then taken, and

a large shadow or series of shadows appeared in the right lumbar region and seemed to indicate the presence of a large stone or of several stones. Examination of the abdomen showed increased resistance in the right flank, muscular rigidity, and an increase in the area of dulness. The temperature was raised so that a perinephritic abscess in addition to calculous pyelitis was suspected. The patient looked very ill when brought into the operating theatre. He was placed on the left side, and the right flank made prominent by placing a large sandbag under the opposite flank. After section of the abdominal wall, there was a sudden rush of pus from a large perinephritic abscess, the cavity of which Mr. Edwards carefully examined with his finger. He detected the kidney at the bottom of the cavity with a fragment of stone projecting from its surface. The opening through which this came was dilated with the finger; it was soon apparent that a large branched calculus was present. Its removal necessitated an incision through the posterior convex border of the kidney in its entire length. The stone was extracted in two parts with a certain amount of difficulty and with free hæmorrhage, to restrain which the kidney was packed with gauze after the surgeon had made sure that the ureter was patent. Two large rubber drains were inserted into the perinephritic abscess cavity, and the wound closed in the usual way. The patient bore the operation better than could have been expected. Mr. Edwards said it was curious that this patient should not have applied before for relief, as he must have had the stone in the kidney for some years. It was a question, Mr. Edwards remarked, as to whether he had done right in leaving the kidney, for it was problematical how much secreting substance remained. If the wound did not heal up fairly quickly the operator proposed to do a secondary nephrectomy, as he thought this was a better course than sacrificing the kidney at once, for after all it might not be necessary. He thought from the size of the stone that the weight would probably be well over two ounces; its length was four inches, the central part was a kind of waist which had occupied the pelvis of the kidney, and from the upper and lower part of the central portions projected elongated knobs or excrescences, which were evidently casts of the calices; hence could be understood the great difficulty in extracting these portions of the stone which were thoroughly grasped by the kidney substance surrounding each calyx.

A month after operation the patient was progressing in a very satisfactory manner, only a very small sinus remaining.

#### Nuns as Nurses.

MR. SLOANE last week asked the Chief Secretary to the Lord Lieutenant of Ireland whether he was aware that at the meeting of the Newry Board of Guardians three nuns from the Convent in Wexford were appointed as nurses to Newry Workhouse; if he could say where these nurses were trained and what was their qualification; and why these appointments were given to members of a religious order. Mr. Wyndham answered that three nuns who were employed in the workhouse infirmary had recently resigned, and the guardians had elected three other nuns in their places. The latter had had several years' experience as nurses in union infirmaries, including that at Wexford. Protestant patients at Newry were in charge of a Protestant nurse.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, AUGUST 24, 1904.

### THE LAST GREAT SACRIFICE FOR HONOUR.

THE annals of civilian life are from time to time illuminated by the record of some heroic act of self-sacrifice. Away from the glamour of military pomp and the stir of battle, some citizen engaged in the pursuits of private life makes the last great sacrifice of his life in response to the call of duty. What greater proof could be given of human faithfulness to high ideals? The bravery of the navy who was killed in saving an express train, and of the driver who stopped his engine deliberately at the cost of his own life, stand blazoned in an undying roll of fame. The recent death of Lady McNeill in an attempt to rescue a little boy visitor from drowning adds another name to the list of honour. The tragedy of that event has suggested to a contemporary—the *Daily News*—the question whether such sacrifice is “worth while.” To put the matter in other words, was it justifiable for a highly-trained member of society to risk her own valuable life for the sake of that of a little child whose value to the community was entirely potential? In a matter of this sort the man of action does not stop to think. He dives into the water without waiting to ask what is the social status of the person he is attempting to save. To the brave man all human life is sacred, and in most cases he is ready to run any reasonable risk in order to save the lives of others. To incur the certainty of death with a remote chance of saving life savours, perhaps, somewhat too strongly of recklessness to constitute bravery of the highest kind. But there is no need to chop moral philosophy over this matter. Happily, the nobler qualities of man survive the sordid struggle for existence into which he is for the most part plunged by the necessities of the case. So long as human nature retains its present characteristics.

so long will men, women, nay, children also be willing to risk their own lives in the attempt to save their fellows. Civilian bravery of this kind often puts in the shade that of the soldier, whose trade it is to deal with life hazards, and to whom every definite risk connotes rewards on an equally definite scale. The miner who heads a rescue party, the railway man who averts disaster from an excursion train, the lad who drags his comrades out of a canal, and the thousand and one civilians who cheerfully risk their lives do it for the sake of mere homespun duty and bravery. To them there looms no peerage or Westminster Abbey in the background. It is only of recent years that a Civilian Order has been created to distinguish civilians who have saved life under circumstances of great bravery. Compare that with the list of honours, titles, orders, commissions, promotions, pensions, decorations and rewards bestowed on the British army in the course of war waged against two small republics in a distant part of the world. The soldier, however devoted and brave, is simply discharging the service which he has contracted to render to the State. The civilian is bound to no one to rescue his fellows from situations of jeopardy by the consideration of reward past, present or future. There can be no greater attribute of man than this readiness to make the last great sacrifice of risking or of sacrificing his life for another. In the medical profession the call arises now and then amid the grey routine of daily work. It is answered, as we all know, in a way that has made us proud of the profession to which we belong. Among strictly professional dangers encountered in that way the most frequent has been the clearing of a choked tracheotomy tube in diphtheria cases by the direct process of sucking the open end. Many a brass tablet in hospitals, and many a stained glass window in infirmary chapels, records the tale of such self-sacrifice, but the heroism of many stands unrecorded to this day. It would be an act of grace were the medical men of to-day to commemorate the names of these heroes who have fallen in the face of one of the most formidable of all infections. In almost all instances, moreover, the life of the highly-trained medical man has been sacrificed in the endeavour to save that of a child or of some individual of less value to the general community. The tradition of such men deserves to be kept green in the memory of their fellows.

#### TEXT-BOOKS ON OBSTETRICS.

A CRITICAL review on some recent American obstetrical text-books appears in the current number of the *Scottish Medical and Surgical Journal* from the pen of Professor Stephenson of Aberdeen. The review taken as a whole may, we fancy, be said to express the opinions of most British obstetricians, though perhaps there are some points in which Professor Stephenson's criticisms are a little over-elaborated. Shortly summarised, he objects to the modern American

obstetrical text-books on the ground of their number, their size, the arrangement of their subject-matter, the unnecessary multiplication of illustrations, the use of micro-photographs, the needless display of the nude, and the encyclopædic character of the books. It is difficult to blame a writer of a book, which purports to be complete, because he says too much, unless he wastes space in mere verbosity, and the latter is unfortunately a charge to which certain of the works alluded to are open. As Professor Stephenson says, "we miss the graphic description, the literary restraint, and the matured opinions of the old masters. The zeal for science is great, so great that it is difficult at times to repress the feeling that much is introduced for rivalry and show." We also miss two other matters to which Professor Stephenson does not allude—the style of the older writers and the use of the King's English "as she is spelt." The illegitimate phrases and words that replace in American books the lawfully derived English originals are pitiable, and are used and adopted not only by native-born Americans, but also by resident Englishmen. We are glad, however, to be able to say that the best of the works which appear on Professor Stephenson's list is singularly free from American peculiarities. We cannot follow Professor Stephenson in his condemnation of micro-photographs. We confess to having formerly held an opinion identical with his—that such illustrations are not successful or instructive, but look learned. It is true that it requires experience to interpret them, but once that experience is gained the photograph becomes instructive in the highest degree—provided that it is a good one. Students of the future will find that it is necessary to learn to read micro-photographs, and having done so, we shall no longer hear that they are not instructive. We can go with Professor Stephenson thus far, that we consider the value of the micro-photograph will be much enhanced by having beside it a key-drawing, which diagrammatically represents the essential points of the photograph. The origin of the American text-book might, we fancy, be found in the dogged persistence with which English works adhere to old theories and old technique. Its present form is the result of the swing of the pendulum slightly too far in the opposite direction, and of the intense desire of certain American writers "to go one better" than their predecessors. It is the tacit approval with which English writers regard repeated vaginal examinations, and their scant allusions to the necessity for aseptic and antiseptic precautions, that has led American writers to write as if condemning all vaginal examinations during labour. On this side of the Atlantic, the danger associated with such examinations has been so persistently under-estimated by the older school, is it any wonder that, with the existing obstetrical mortality, a younger school should tend to the contrary error of over-estimation?

#### ST. JOHN AMBULANCE ASSOCIATION.

A PAPER of great practical interest was read by

Dr. Hamilton, of Newport (Mon.), in the Naval and Military Section of the British Medical Association meeting at Oxford. This paper contained a number of friendly criticisms on the work of the St. John Ambulance Association, and we agree with Dr. Hamilton that this valuable association would be of considerably greater service to the public if some of its methods were subjected to revision. Great credit is due to the association, and to two or three energetic medical men who early allied themselves with it, for having demonstrated first of all the practical utility of such work, and, secondly, the ease with which its application could be acquired by lay persons of no great general education. It is the fashion in many professional quarters to scoff at the enthusiastic first-aiders who arrive panting at the scene of an accident, armed perhaps with a medallion, and offers, on the strength of a few lectures and demonstrations in the use of splints and bandages, to take charge of the patient. No doubt there are cases in which zeal outruns discretion, and we have even heard of instances in which an unobtrusive doctor has found himself supplanted by these ardent amateurs. But we believe these occasions to be rare, and in busy industrial centres and on great railways the practical value of instruction in the immediate treatment of accidents given to servants has been shown over and over again. So long as the first-aiders recognise his limitations, he will do little harm, and he has already undoubtedly averted much suffering, and on some occasions even death itself. When it is remembered that a life of the value of Nelson's was retained for his country's service through the timely application of a scarf by his lieutenant, it behoves one to be chary in joining in the chaff bestowed on those who give up their leisure time to attain skill in the art of acting judiciously in emergencies. On the other hand, Dr. Hamilton is quite right in drawing attention to the low standard of proficiency required by many of the examiners of the St. John Ambulance Association, and to the still more urgent need of continuing the training of the candidates after the first certificate has been gained. The course of instruction mapped out is a good one on the whole, but the number of lectures is quite inadequate for any teacher to convey to persons unacquainted with the elements of anatomy and physiology a tithe of the ideas on which alone correct treatment can be founded. The association naturally wish to secure good returns at the end of the year, so they spread their net widely in the effort to attract candidates for instruction, and it is doubtless satisfactory to them to be able to show a high percentage of passes in their examinations. But it is a matter of grave doubt whether the certification of a large number of imperfectly trained persons as competent to render first aid is not, as it stands, a positive danger to the community. Hundreds of holders of certificates will honestly confess in a couple of years after they have passed the examination that they have forgotten *in toto* all that they

had learned, and even those recently passed make mistakes that would be ludicrous if they were not apt to be attended with serious consequences. In his paper Dr. Hamilton cites a number of instances of misapplied ingenuity that have come within his purview, and most readers will be able to supplement these from their own experience. Now the discredit thrown, and rightly thrown, on instruction that produces these effects is likely to prejudice the whole of this useful movement, and we think the St. John Ambulance Association would do well, while pushing their classes in every legitimate manner, to make their courses longer and more thorough, and their examinations more searching. The number of candidates would probably fall off, but the general utility of the movement would rise. It cannot be gainsaid that the public would be better served by a quarter of the present number of first-aiders if trained to the standard of the teams that take part in the annual competitions. The efficiency of these teams to act in emergencies is as far beyond dispute as is the uselessness of half the lackadaisical young ladies who entertain themselves on winter evenings by listening to the oratorical efforts of perspiring young practitioners who see in ambulance classes a legitimate avenue to local fame. Candidates who are "keen" will take trouble to make themselves efficient; those who are careless need not be encouraged. They will be no loss to anyone. The classes for instruction should certainly be taught for a much longer period than at present, and the question of diagnosis of injuries should be more strongly insisted on. The examiners, taking their cue from the teachers, should make their tests more practical, and should assure themselves not only that the candidate knows how to apply prompt treatment, but that he is likely to recognise the nature of the injury which a patient may be suffering from when he is called upon to help. As things stand, most candidates have never examined an injured person, and when confronted with an accident, stand but a poor chance of diagnosing a fracture from a dislocation, or an epileptic fit from opium-poisoning. Moreover, as Dr. Hamilton insists, it is of vital importance that the holders of certificates should assemble at intervals for practice in their art, lest their little store of knowledge evaporate altogether, and their efforts become a source of danger to their patients. No art can be retained without dint of constant practice. The St. John Ambulance Association have done well in the past; that, however, is no reason why they should not do a great deal better in the future.

### Notes on Current Topics.

#### A New Field for Pharmaceutical Chemists.

It appears that a new field of work is in process of exploitation by chemists, with the direct help of the Pharmaceutical Society. As our readers know, a society known as the Spectacle-Makers' Company has formed itself for the granting of diplomas

to anybody who passes certain examinations, such diplomas testifying that the holder is specially capable of diagnosing various conditions of the eyes, fitting glasses, &c. Chemists have turned longing glances towards the increased profits that might be made by exhibiting the diploma of the Spectacle-Makers' Company and by fitting glasses on the public, but unfortunately they did not feel inclined to pass "in the subjects of mathematics and heat in the special examination for the diploma in general and visual optics" of the Company. Accordingly a new Society was formed—the Society of Chemist-Opticians, and during the first week of its existence it succeeded in obtaining from the Spectacle-Makers' Company the important privilege that qualified chemists may obtain the diploma in general and visual optics "without the necessity of adding to their knowledge on the subjects of mathematics and heat." Further, the new Society has succeeded in interesting the lecturer on Chemistry at Bloomsbury Square and the Council of the Pharmaceutical Society, with the result that special apparatus is to be obtained for the purpose of teaching the coming chemist how to prescribe glasses. Personally, we are believers in the old proverb—*ne sutor ultra crepidam*.

#### Hygienic Aspects of Religion.

ENDLESS discussion occurs over the so-called conflict of science and religion. In the past vigorous combat has been waged by the respective disciples, and it cannot be denied that many would-be scientists have trespassed from the region of the known into the realm of the unseen and discountenanced much that was peculiarly dear to the faithful. But history is full of evidences of the mischief wrought by religious fanatics who, in their ignorance, have used every effort to hamper the progress of science, and particularly to curtail the service of the healing art. Religion, however, in all lands and in every age has played an active part in directing public and personal hygiene. The importance of health matters has always been insisted upon by the Jews, and the health of other peoples has been extensively influenced by the injunctions of their religious code. It is well to recognise religion as an essential factor in the evolution not only of a people but of each individual. We have no wish to cast reflections upon any religious system which is held in reverence, either in this or other lands, but we are strongly of opinion that medical practitioners, whatever may be their individual religious views, have an absolute duty to discountenance an all too prevalent sacerdotalism which not only encourages but insists upon the carrying on of non-hygienic procedures as necessary religious functions. We are most reluctant to say one word which should bruise the sensibilities of even the most sensitive, but it is necessary to remind dogmatic exponents of certain religious beliefs that they are advocating measures which seriously threaten health, and oftentimes are active in the propagation of actual disease. And we hold that what is scientifically wrong is also religiously wrong.

#### The Disease of the "Ego."

THE consciousness of the "ego" may be classed as one of the prominent symptoms of our times. The psychical phenomenon of which this form of self-consciousness is the immediate manifestation is, of its nature, morbid. The healthy, normal individual, whose muscular system predominates over his cerebral functions, experiences no more concern about his *ego* than about his heart or digestion, in fact, in a state of perfect health and equilibrium all the functions pursue the noiseless tenour of their way without attracting attention or criticism. When one becomes aware of the existence of an organ, in other words, when an organ obtrudes itself on our attention, there is *prima facie* reason to suspect disease or, at any rate, disturbance. Similarly, when a man turns his eyes inwards and begins to scrutinise his psychical entity he is probably on the borderline of neurasthenia. It is a sort of mental "globus hystericus," a subjective sensation which has no anatomical basis, a projection on to the field of consciousness of the result of disturbed cerebral circulation. Only the strongest brains can endure this sustained process of introspection without permanent damage and, fortunately, the pastime is one which the average mind finds little inducement to indulge in.

#### Leishman-Donovan Bodies.

No department of things medical has of recent years expanded at such a bewildering rate as that of tropical medicine, and the stay-at-home practitioner finds himself at a loss to keep pace with the new discoveries and theories that come crowding into the medical journals every week. The whole subject of tropical diseases has been revolutionised during the last decade, and the workers in this great field are rewarded for their efforts in a manner that dazzles the patient plodder in the prosaic laboratories at home. It is little over a year since Majors Leishman and Donovan independently discovered the bodies that are now known by their joint names; yet fresh facts with regard to their nature are reported home by almost every mail. These bodies were just obtained by puncture of the spleen of patients suffering from chronic cachexial fevers, though they could not be demonstrated in the circulating blood. Stained by the Romanowsky method, they are found partly free and partly enclosed in the red blood corpuscles, and show at one end a mass of chromatin united often by a thin process to a smaller mass. They contain no pigment, but the larger mass often shows signs of fission. The parasite has been regarded as a *Pyrosoma*, the best example of which is the organism that causes Texas fever, the epidemic hæmoglobinuria of cattle. Another is the parasite found in the tick fever of the Rocky Mountains. The Leishman-Donovan bodies have been widely searched for and have now been demonstrated in a large number of morbid conditions. In Kala-Azar, the wide-spread cachexial fever of Assam, they have been found in the hypertrophied spleen, and in "Delhi sore" the ulcers



themselves have been shown to contain these bodies, as have the spleen, liver, intestine, lymph-glands, and bone-marrow. The sensational announcement of Captain Rogers of his ability to cultivate trypanosomes from the Leishman-Donovan bodies throws a new and unexpected light on their nature, as it would now appear that man is the intermediate host for the asexual cycle of these parasites, the adult form being the trypanosome which attains maturity in the lower animals. It is to be hoped that this interesting subject may soon be thoroughly understood, as in the parasitology of these pathogenic forms lies the key to most of the unhealthiness of tropical countries.

#### Quinquaud's Sign.

A NEW sign of chronic alcoholism has been lately brought to notice from several quarters, and as it appears to be well authenticated medical men may be glad to avail themselves of such information as it affords. The sign was first discovered by Quinquaud, but was not published to the world till seven years after his death. Since then Maridort and Fürbringer have both directed attention to it. The sign is elicited by making the patient place the tips of his fingers, well spread out, perpendicularly against those of the examiner, when, if the patient is of alcoholic habits, the examiner feels a number of slight shocks as if the phalanges of the patient were rapidly pressed against each other and against the palm of the examiner. The sensation experienced by the examiners is said to be similar to that of crepitus such as is felt in arthritis deformans, but it has also certain indescribable peculiarities of its own. This crepitus can be heard by the stethoscope and sounds like friction, though in autopsies on patients who have exhibited it, no undue dryness or roughness of the articular ends of the bones has been found. Nor has it any relationship with alcoholic tremor, for whereas Fürbringer found marked tremor in only 7 per cent. of drinkers, he found Quinquaud's sign present in nearly 92 per cent. The pathology of the condition that produces this creaking is very obscure, and after discussing it, Fürbringer concludes that it must be a neurosis, but this result is arrived at more by excluding organic causes than by any positive evidence of nervous derangement. The sign is not likely to be of much practical value, but it is certainly an interesting clinical phenomenon.

#### Paracentesis in Pericardial Effusions.

THE tolerance which most of the closed cavities of the body exhibit towards an accumulation of fluid, especially when gradual, affords a remarkable illustration of the indifference shown by living tissues to foreign bodies as long as the latter do not possess any markedly irritating properties. The pericardium, which normally contains only just sufficient fluid for lubrication, may, like other serous membranes, hold a large amount of exudation without causing much inconvenience. Pericardial effusions have attained as much as 4,000 c.c. (seven pints), but such an enormous quantity is

phenomenal. When of large size they are as a rule purulent in character. The diagnosis of fluid within the pericardium is often a matter of difficulty, the condition being sometimes mistaken for pleural effusion. The shape of the area of dullness is the most conclusive sign. The question of paracentesis will become more and more urgent as the gravity of the case increases. Small effusions may occasionally be caused to disperse by means of counter-irritation in the form of leeches or blisters applied to the præcordium combined with the administration of diuretic and cathartic drugs, but actual mechanical removal of the fluid is the only possible mode of treatment for a large effusion. When cardiac embarrassment is well marked no time should be lost in inserting a fine trocar and cannula. Dr. W. S. Thayer, (a) of the Johns Hopkins University, has reported two cases of tuberculous pericarditis with effusion in which paracentesis was performed. In one case over 1,250 c.c. of purulent fluid were withdrawn with considerable benefit. The dangers of this procedure are not great in careful hands, the risk of infecting the pleura being inconsiderable, except in very large effusions. Puncture of the heart, an accident to be avoided, is not necessarily attended with serious consequences. The seat of election for insertion of the needle is in the fourth or fifth left intercostal space, close to the sternal border.

#### Fatal Kindness of a Hospital Visitor.

THE recent disclosures at an inquest upon a poor girl who died in a provincial hospital from perforation of a gastric ulcer serve to illustrate the supreme importance of diet as a factor in certain forms of disease. The deceased, a domestic servant, was lying in a ward seriously ill and had been placed on a rigid diet. Through the mistaken kindness of a fellow-servant she drank a bottle of lemonade, a liquid which can hardly be considered an ideal beverage in a case of gastric ulcer, with the result that she died. The circumstances which allowed such a breach of discipline to take place will, probably, never be fully understood, but it is a lamentable fact that cases of a similar nature occur under the most vigilant circumstances every "visiting" day. Patients' friends smuggle apples and buns into hospital wards, in spite of printed warnings and the sharp eyes of the nurses in charge. Popular ignorance respecting the why and wherefore of "low" diet is so widespread that persons who should know a great deal better sometimes protest the most loudly against the "cruel starvation," as they call it, endured by such a course. Life or death may hang absolutely upon the regular administration of a minute quantity of fluid nourishment, and any abrupt departure from this mode of feeding may be fraught with disastrous results, to wit, in cases of enteric fever. A case occurred not long ago in a London hospital where an irate and utterly irrational parent insisted upon removing her son, who was suffering from typhoid, from the ward and giving him a hearty meal, with

(a) Bull. Johns Hopkins University, May, 1904.

the consequences that might be expected. Such fools' kindness is simply criminal, and in the case of the domestic the jury's censure might have been far stronger than it actually was. The lemonade killed the patient, and the foolish woman who broke the rules and gave that lemonade was directly responsible for the ensuing death.

#### The Glass House Residences of Medical Writers.

A CORRESPONDENT who has had the pleasure of submitting to Professor Clifford Allbutt theses for the M.B. and M.D. degrees of the University of Cambridge writes to us as follows: "We Cambridge men are all proud of our Regius Professor of Physic, and have derived not only real profit from his medical writings but infinite pleasure from their literary form. We owe him, too, a debt of gratitude for his efforts to turn out Cambridge medical graduates who possess scholarly as well as scientific attainments—men of letters as well as good doctors. But *humanum est errare*—even in literary composition—and I fancy that Professor Allbutt's sly humour, which lends such a charm to his writings, will appreciate a little *riposte* from one of the thesis-writers whom he so justly hauls over the coals in the pamphlet you describe in your instructive leader of this week. In composition it is difficult at all times to avoid that kind of fault which one recognises as soon as it is pointed out—faults which are specially apt to creep into what I believe the Americans call "sun-down" literature—namely, writing undertaken in addition to the ordinary routine of the day, and executed when the rest of the world is in bed. But what I should like to draw your attention to, sir, is the following sentence from a letter of Professor Allbutt to the Editor of the *British Medical Journal* of May 23th, 1904. Professor Allbutt is writing about the Government Lunacy Bill, and he appeals to his own experiences when Lord Chancellor's visitor in lunacy. The sentence runs—"Let us be thankful that in the obscurity of these English homes I found, or rarely found, any positive evil." The meaning is obvious, but if Professor Allbutt had inserted one of those negatives that his pupils use so freely, his sentence might have been more correct from the literary point of view. Or was the omission of the negative a passive protest against the redundancy in vogue among thesis-writers?"

#### Work of the National Veterinary Association.

THE annual meeting of the National Veterinary Association was held in Dublin during the past week. Dr. Charles Allen, the President, delivered an interesting address, in the course of which he referred to the recent report of the Commission appointed to investigate the whole question of the transmission of tuberculosis. The whole subject constitutes one of the most supreme interest to the veterinary world. The President next referred to the work at present being done by the Cancer Commission. It was a work in

which the veterinary profession could give valuable assistance, and he was glad to know that many specimens of value from their body had reached those who were doing the work of the Commission. He concluded by referring to the present position of the Royal Veterinary College of Ireland, which four years ago had only existed on paper. A paper on "Epizootic Lymphangitis" was then read by Captain Martin, A.V.D., and another by Professor Woolridge, on "Hæmoglobinuria in Bovines."

#### Copper Sulphate: Friend or Foe?

FOR some reason or other the Health authorities seem to have taken particular umbrage against the presence of copper in preserved peas. Why they should pass by in comparative neglect the wholesale adulteration of the daily food of the people to concentrate their attack on a comparatively unimportant article of consumption is somewhat of a mystery. A recent police-court prosecution resulted in the conviction and fine of a grocer for selling peas and French beans adulterated with sulphate of copper to the extent in the beans of 3.402, and in the peas of 4.00 grains to the pound. The Departmental Report of 1899, by a minority report, recommended that in no case should more than half a grain of metallic copper be permissible to the pound of preserved peas. The prosecuting Medical Officer of Health admitted he knew of no case where injury had resulted from coppered peas. He stated that the ordinary dose of sulphate of copper as an astringent was from half to two grains. Anyone, therefore, taking a pound of the particular peas in question would swallow double the medicinal dose. Phyllocyanate of copper was formed when copper was added in small quantities to peas, a substance that in minute quantity paralysed, and ultimately killed dogs. That fact, apart from the mere question of adulteration, suggests that copper should be used with extreme caution as a medicinal agent. Indeed, its therapeutic use is nowadays extremely limited, as of late years other remedial methods and non-toxic astringent drugs have been introduced into practice. Meanwhile it is to be hoped that the sanitary authorities will regard the prosecution of the sellers of coppered peas as merely a step in the right direction.

#### The Medical Inspection of Schools in Ireland.

AN important paper bearing on the above subject was read by Dr. Edward Magennis at the recent Congress of the Royal Institute of Public Health, at Folkestone. The pith of the paper is that the present neglect of the elementary principles of hygiene in the National schools through the country constitutes a very serious danger to the life of both teacher and pupil, and that the best method of remedying this unfortunate state of affairs would be to attach a Sanitary Department to the Board of Education with medical officers to examine and certify every school. We learn that there is a daily average of something like

850,000 children attending the different primary schools through Ireland; and that the school accommodation is only sufficient for 736,000 even when each child is limited to the apparent minimum of ten square feet of floor space. If the figure of the air-circulation through these places was also known, it would be shown that there was an even greater discrepancy between the necessary minimum of fresh air and the actual amount supplied. We have ourselves frequently passed schools crammed with children, and without any apparent means of ventilation, save what was afforded by the chimney and the cracks beneath the windows and door. We have no hesitation in saying that no theatre, music-hall, or other place of amusement would be sanctioned by the sanitary authorities which deprived its audience of space and of air in the manner that is done by the Irish school authorities. Yet no one is obliged to go to a theatre, while children are compelled to spend the best hours of their childhood in the pestilent atmosphere of the National school. Educationalists and politicians wrangle over the particular form of history or geography to be taught, and spend hours discussing whether a language is of living commercial value or of dead respectability; statisticians and sanitarians lament the terrible ravages wrought by tuberculous disease in Ireland, yet the Irish National schools continue to perform their deadly work on one generation after another of "scholars." If Dr. Magennis succeeds in rousing the Board of Education, he will have accomplished a most valuable task.

#### The Railway Lavatory.

At this season of the year everyone is "at home" on the railway. All sorts and conditions of people collect at our stations and travel in our trains. Oftentimes a departure platform is a veritable hospital where disease in manifold variety may be demonstrated. Tuberculous, syphilitic, cancerous, all congregate at the booking office and no one can deny them the privileges of the traveller. Many of the railway companies have done much for the safety and protection and comfort of their passengers, but during the present year in travelling over a considerable portion of the railway system of this country we have been struck by the many glaring sanitary deficiencies and hygienic defects which abound. At the present time, however, we would draw attention only to one which we believe is liable to lead to much physical disaster. Lavatories are essential to the mental comfort and bodily well-being of railway passengers. In large stations excellent conveniences are usually available, but in country districts and wayside stations arrangements are oftentimes most primitive and altogether insanitary. In many stations we have recently visited, the urinals are ill-constructed, badly drained, imperfectly cleaned, and disgusting to the senses. It would be well if medical officers of health paid more attention to the sanitary deficiencies of railway stations in their

districts. Lavatories are now to be found on practically all our long-distance trains, but even in first-class carriages we have constantly found the closets ill-constructed, imperfectly supplied with necessities, oftentimes dirty and frequently of such a form that all excreta is deposited upon the line, it may be in a busy station. At this holiday season of the year there is urgent need that the sanitarian should insist on the carrying out of prophylactic measures, and foremost among them we would place reform of the railway lavatories.

#### Medical and Dental Companies.

THE extent to which the evil of permitting the registration of companies for the practice of medicine and dentistry has gone is shown by a list of such companies published by our contemporary, the *Chemist and Druggist*. In England alone, there are sixty-two companies registered for the practice of dentistry. In Ireland, there are twenty-two; and in Scotland three. In England, there are fifteen companies similarly registered for the practice of medicine, but in Ireland and in Scotland there are none. The recent decision of the Chief Baron of Ireland has had the effect of checking the registration of such companies, and steps are being taken to deal with those already registered. It is obviously impossible that half a dozen men acting in a corporate capacity can be allowed to perform acts that would be illegal for any of them acting in an individual capacity, and to set at naught the Medical and Dental Acts. The Irish Dental Association deserves the entire credit of having been the means of bringing about a stoppage in the registration of these companies, and we trust that it will continue its efforts until those already registered have been compelled to discontinue their operations.

#### Abdominal Venosity, "Good Capon Lined."

ABDOMINAL venosity is a convenient euphemism for the condition induced in the viscera by a too great laxity of the abdominal walls, and it enables the medical attendant to discuss the evils of a state brought on by high living and sedentary existence without offending the susceptibilities of his patient. The man who would not care to have his "little Mary" described as a "pot-belly" rejoices in being able to tell his friends that his sufferings are due to abdominal venosity. In fact, the term is as great a God-send to the family practitioner's vocabulary as the suggestion of "adipose deposit" for "superfluous fat." To the home and Continental spas abdominal venosity has brought many a shekel, for the plethoric man feels it a duty to his conscience to make some sort of effort to appease outraged Nature—that is, if the effort does not incommode him unduly. A well-known physician has lately suggested a plan which, if faithfully carried out, should render recourse to a spa unnecessary, as every sufferer has the apparatus required for the treatment ready to hand. The object aimed at is to strengthen the muscles of the abdominal wall in order that more

support may be given to the enclosed viscera. There is no exercise so well adapted to this end as rowing, but every city man cannot repair regularly to the river and disport himself in an "eight" or a skiff. A stay-at-home method has therefore been devised. The patient has to divest himself of all superfluous clothing, open his window, and pull out the bottom drawer of his chest of drawers. He then lies at full length on the floor, his feet tucked under the pulled out drawer and his arms extended over his head. The victim proceeds to raise himself into a sitting posture by means of his abdominal muscles, taking care not to advance his arms in front of the line of the trunk. Having gained the sedentary position he lets himself down again, and repeats the performance till the calls of bath and breakfast make themselves heard. Next day he returns to his diversion, and thus he continues till his waist assumes enviable proportions. We have no doubt that the exercise is a splendid one for the purpose, but we should think that no man would appear less of a hero to his own valet than a City Alderman in light attire wrestling with a chest of drawers before breakfast. If he could be induced to do so, the benefit likely to accrue would doubtless be great.

#### **An Irregular Method of Dispensing.**

A CURIOUS case was heard recently before the City Magistrates at Birmingham. A man called Heath, a chemist and druggist, was asked by a messenger from the Health Department to make up a prescription containing twenty-four doses of a quinine mixture, each dose of which was to contain ten grains of quinine and ten minims of dilute sulphuric acid. The defendant made up the mixture and charged two shillings for it. On analysis, it was found that the bottle contained altogether only twenty-three grains of quinine and 141 minims of dilute sulphuric acid. The defendant stated that he would not think of putting half an ounce of quinine into a six-ounce mixture, that if he had done so he would have charged five shillings for the bottle, that he thought a mistake had been made in writing drachms instead of grains and that the prescription was so well written that he did not think a medical man had written it. The magistrates considered that up to a certain point the defendant had exercised a proper discretion, but that he should have obtained the name of the writer of the prescription and communicated with him. They considered that he was negligent and imposed a penalty of forty shillings. The decision appears to us to be warranted by the facts of the case. Ten grains of quinine is a large dose, but how many Anglo-Indians and men who have lived for long in malarial climates would think nothing of twice as much? The price of the twenty-three grains placed in the mixture was about a penny, while that of the 240 grains which were ordered would have been about ninepence: where, then, did the difference of, three shillings in the price of the mixture come in? The point regarding the hand-writing is absurd, and, if it suggested the need for caution, such caution

could have readily been exercised in the manner suggested by the magistrates.

#### **Multiple Tests for Drunkenness.**

OF a truth there is nothing sacred to the hand of science. All the deeply-rooted beliefs of mankind are being ruthlessly torn up and cast into the oven. Take the test of a drunken man. Our forefathers did well enough by asking him to say "truly rural," and to walk a line chalked along the floor. But the medical man to-day will have no parley with rough and ready methods of that kind, fitted only for the ruder efforts of a pre-scientific age. Nowadays, even the ambulance student knows—in theory, at any rate—how to tell the unconsciousness due to alcohol from that of brain mischief. As to the police surgeon, his tests have become simply multitudinous, if we may judge from the report made last week by a London gentleman upon the soberness of a warehouseman charged with singing and dancing on the public footway while drunk. The surgeon confirmed the police charge, and stated he found fifteen symptoms of inebriety. From a scientific point of view it would be of interest to learn how many of those symptoms were due absolutely to alcohol, and how many were capable of a different interpretation. Science is a good thing in its way, medical science, perhaps, especially so, but with multiple symptoms at command the question naturally arises, how is it that persons are so often allowed to die in police cells under the impression they are drunk? The proof of the pudding is in the eating. We doubt if a trustworthy system of detecting drunkenness in police cells has yet been devised.

#### **The Scottish Diplomates' Association and the Title of "Doctor."**

ONE of the avowed objects of the newly-formed Association of Scottish Diplomates is to secure for its members legal recognition of their right to the title of "Doctor." This desire, in the eyes of the *Hospital*, is no less foolish than unjustifiable, and an intimation to that effect has been recently published in the columns of that journal. It is, of course, well recognised by all who are really within the medical circle and are thus acquainted with the trend of professional thought that a considerable injustice is inflicted upon medical diplomates by restricting the title of "Doctor" to the holders of University degrees. The acquired modern sense of the word, to the man in the street, is that of a practitioner of medicine, and it matters not to the average citizen one jot whether his medical attendant was educated within the walls of a university or of a less assuming medical school. The underlying moral of the whole thing is that there should be one portal of admission to the practice of medicine, and one distinguishing title for all who have passed that portal. The feeling of the Scotch diplomates on this point is perfectly natural and laudable, and they will do well to educate the British public somewhat as to the precise value

and meaning of the present multitudinous medical qualifications. In its desire to pour cold water on the policy of the Scottish Diplomates' Association the *Hospital* appears to overlook the fact that the title of its members forms a small detail in a wide and comprehensive programme.

#### PERSONAL

HIS MAJESTY THE KING has been pleased to approve the appointment of Dr. William Osler, D.Sc., F.R.S., to be Regius Professor of Medicine at Oxford, in succession to Sir John Burdon Sanderson, Bart. In 1889 Dr. Osler was appointed Professor of the Principles and Practice of Medicine in the University of Pennsylvania and Physician to the Johns Hopkins Hospital, Baltimore.

MR. C. MOLESWORTH TUKE, M.R.C.S., has been elected President of the West London Medico-Chirurgical Society for the ensuing session, 1904-5.

DR. BERTRAM ABRAHAMS has been appointed Examiner in Physiology to the Conjoint Board of the Royal Colleges of Physicians and Surgeons of England.

THE War Office authorities are desirous of communicating with three ladies, Miss M. C. Bakkes, Mrs. Rutherford, and Miss M. B. Horswell, with reference to the services performed by them as nurses in the Boer refugee camps in South Africa during the period 1901-1903. Any information as to the present addresses of these ladies should be addressed to the Secretary, War Office, Pall Mall, London, S.W.

THE Commission for the Investigation of Pneumonia in New York will consist of the following well-known physicians: Dr. William Osler and Dr. William H. Welch, of Johns Hopkins University; Dr. Edward C. Janeway, of New York University; Dr. J. Mitchell Prudden and Dr. L. Emmett Holt, of the New York College of Physicians and Surgeons; Dr. Frank Billings, of the Rush Medical College of Chicago; Dr. John H. Musser, of the University of Pennsylvania; and Dr. Theobald Smith, of Harvard.

DR. LORRAIN SMITH, Professor of Pathology at Queen's College, Belfast, who has been recently appointed Professor of Pathology at Victoria University, Manchester, is an *alumnus* of the University of Edinburgh.

It is announced that the King of Greece has bestowed the Gold Cross of the Royal Order of the Saviour upon Sir William Bennett, K.C.V.O., F.R.C.S.

DR. GEORGE F. SHRADY has resigned the editorship of the *New York Medical Record*, after thirty-eight years' service in that capacity. He is succeeded by his former assistant editor, Dr. Thomas L. Stedman.

MR. J. HENDERSON SMITH, M.B. Edin., has been appointed to the Philip Walker Studentship in Pathology at Oxford University for a period of three years.

CHARLES GIBSON, M.D., has been recently commissioned by the Lord Chancellor as a Justice of the Peace for Harrogate.

DR. D. J. COFFEY, Professor of Physiology at the Cecilia Street School of Medicine, Dublin, was presented by the Keating Branch of the Gaelic League with a handsome collection of Gaelic works, on the occasion of his recent marriage. The books consisted of Dr. O'Donovan's edition of the "Annals of the Four Masters," and Sir O'Grady's "Silva Gadelica."

MR. JOHN TWEDDY, President of the Royal College

of Surgeons of England, has promised to take the chair at the annual dinner of past and present students of the Medical Faculty of University College, London, on Monday, October 3rd.

THE Paris Municipal Council has voted a grant of £120 to Professor Grancher in furtherance of his researches as to the means of preventing tuberculosis in schools.

### Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENT.]

#### BELFAST.

RESIGNATION OF PROFESSOR LORRAIN SMITH.—The members of the medical profession in Belfast have heard with great regret that Professor Lorrain Smith is resigning the chair of Pathology in Queen's College, having been appointed to Owens College, Manchester. Though some formalities remain to be carried out before the actual resignation takes place, it is understood that Dr. Smith will leave Belfast before the winter session opens. He came to Belfast about eight years ago as Lecturer on Pathology and Bacteriology, and when the late Sir James Musgrave founded the chair of those subjects, Dr. Smith was its first occupant. His keen interest in scientific medicine has made his name well known far beyond Ulster, and his great personal kindness and readiness to help in every way in his power have made him a universal favourite in the profession. Considering the intimate relations which subsist between the leading pathologist of the school and its other members in the city, the choice of his successor must be a matter of deep interest to them. It is believed that Dr. Thomas Houston will be a candidate for the chair. He has been for several years Professor Smith's right hand man, while he has held the Royal University Studentship in Pathology, and the British Medical Association Research Scholarship. His excellent work on the blood in pernicious anæmia and allied diseases has attracted much attention, and his candidature for the chair is favourably commented on by the members of the Belfast school.

THE SMALL-POX OUTBREAK.—Small-pox has now broken out in a number of towns in Ulster, as was only to be expected when it was prevalent in Belfast. So far, the worst town is Armagh, where there are fourteen cases under treatment, as well as a number of suspects under observation. The beds in the small-pox hospitals are all occupied, and if any further cases occur they will be treated in the wards of the fever hospital. A case was discovered in Clones and removed to the fever hospital, where the patient died. Cases have also occurred in Omagh and Monaghan. There was only one new case in Belfast last week, and none for a fortnight before, so the worst of the outbreak seems over as far as this city is concerned.

The annual report of the President of the Queen's College, Cork, has been issued during the past week. The report states that the number of students attending the College during the last session was 225, as against 190 during the session 1902-3. The number of new students was 68, of whom 52 came from the Royal University of Ireland, 9 from other colleges and universities, while 7 were not matriculated. The President alludes to the great improvement that has taken place in the pathological department since the appointment of Dr. Moore as Lecturer in Pathology. The latter gentleman has instituted post-graduate classes in addition to reforming the method of teaching. The President has, however, to regret that there is a decided indisposition on the part of students of the college to read for honours at the Royal University examinations. It appears that the claims of the College to obtain an examinership in chemistry at the Royal University have been laid before the Senate, but that so far the claims have not been satisfied, in spite, as the President points out, of the unquestioned distinction of Dr. Dixon, the Professor of Chemistry.

## Correspondence.

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

## THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Challenged with having stated that "in 1884 the total birth-rate stood at 31," whereas the birth-rate of England and Wales of that year was 33·6. Dr. Walsh explains that it was the birth-rate of the United Kingdom, and not that of England and Wales, that he quoted. But that will not do, for the birth-rate of the United Kingdom for 1884 was 32·2 and not 31, and was lower than that of England and Wales only by the inclusion of Ireland which, as Dr. Walsh very well knows, has always, for special reasons, had a birth-rate much lower than the other parts of the United Kingdom. In 1884 the birth-rate for England and Wales was 33·6; that of Scotland 33·7, that of Ireland 23·9. The argument which Dr. Walsh founded on the assumption that the birth-rate in 1884 was only 31·0 therefore falls to pieces.

Dr. Walsh falls into other extraordinary blunders. Let me give one as an example: he actually declares that had there been no decline in illegitimacy "we should have had a birth-rate of practically 30·0 in 1904, compared with 31·0 in 1884." I have unfortunately no fore-knowledge of what the returns for 1904 may be, and for the moment I have not access to the vital statistics of the United Kingdom, but the figures for England and Wales for 1902, when compared with those for 1884, are strangely at variance with Dr. Walsh's allegation. Leaving illegitimate births out of the question, the birth-rate for 1884 was 32·0, and for 1902 it was 27·4. During the period covered by these dates the illegitimate birth-rate fell from 1·6 to 1·1, and it has therefore affected the general birth-rate to the extent of 0·5, so that if there had been no decline in illegitimacy the general birth-rate would have stood in 1902 at 29·0, against 33·6 in 1884. This is apparently what Dr. Walsh calls "not far off a level." But all that Dr. Walsh says about the illegitimate birth-rate really strengthens Dr. Taylor's position and weakens his own. Be the fall in that birth-rate what it may, it may be due to the increasing morality of our people, but it may also be due to their increasing addiction to those practices which Dr. Taylor has denounced, which are more likely to be resorted to outside wedlock than in it. The loose way in which Dr. Walsh handles figures puts him almost outside the pale of statistical controversy.

Referred to the Report of the Royal Commission on the Decline of the Birth-rate and on the Mortality of Infants in New South Wales, Dr. Walsh disposes of it by a novel and elegant metaphor, affirming that "Social and economic conditions in New South Wales and in the Mother Country are as chalk is to cheese." They who know our Premier Colony a little better than he does will probably assure him the difference between it and the Mother Country is not greater than that between Cheddar and Double Gloucester, and that human nature in its sexual relations is pretty much the same in London and Sydney. At any rate, he should study the Report, a most weighty and convincing public document, in which he will find a complete and crushing refutation of some of his own fallacies. The Commission, composed of fifteen of the most eminent men in New South Wales, included six medical men, and took the evidence of all the leading members of the profession in the colony. The conclusions at which it has unanimously arrived are well calculated to disturb the smug complacency in which Dr. Walsh would have us wrap ourselves up.

I am, Sir, yours truly,

August 19th, 1904.

LL.D.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—So much has been already written on this very important, I might venture to say *national*, subject

that it is almost impossible to add aught thereto that has not been already said by previous writers. Perhaps, however, you will permit me to preface the brief remarks I propose making by giving the Registrar-General's summary for the last week for London. It runs thus:—"Allowing for increase of population, the births were 39·4 and the deaths 33 below the average." Similar official reports are given weekly, varying only in numbers, from which it is proved to demonstration that a diminishing birth-rate is a reality and not a fiction. The same may be affirmed without contradiction of the death-rate, so that the loss on the one hand is counteracted to a certain extent by a gain on the other, which gives us a greater proportion of adult to infant life. "So far so good," but a continuation of these proportions must necessarily be limited, and a diminishing birth-rate eventuate in a greatly reduced manhood. Of course, it may be said that the Metropolis is not the United Kingdom, and that for accurate comparison statistics of the whole should be given; but as Greater London contains a population of about one-sixth of the home territory, it may be admitted as a fair basis to go upon. We then arrive at the two points of discussion: First, Dr. Taylor's contention that there is a serious and continuous falling off in the birth-rate, attributable to the prudential motives of modern married folk, which will eventually prove destructive to the British race; secondly, the view held by Dr. Walsh and others that this diminution applies to extra-marital as well as marital conditions, and is only in part due to preventive practices. Other correspondents, again, think prevention is incumbent upon, nay, even necessary to, the well-being of the nation at large. I candidly confess my sympathy with Dr. Taylor's view, believing as he does that a stagnant population becomes a decadent one. Present indications, however, hardly point to this conclusion, but rather to degeneracy than disease; and herein there opens up a wider and more absorbing question than the mere increase or decrease of births, the solution of which the Government and thoughtful minds generally are now endeavouring to read. Unfortunately the decreasing birth-rate is clearly traceable to the ranks of the great middle-class, whose ancestors made our nation strong; whilst the feeble, the degenerate and the criminal sections increase and multiply regardless of consequences, and in this lies the national danger. On prudential grounds individualism is justified in not bringing more children into the world than parents can reasonably hope to keep and educate; but such motives, commendable as they are in the abstract, are entirely one-sided and tend to the ultimate replacement of the morally and physically strong by the mentally and physically weak.

I am, Sir, yours truly,

CANTAB.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have watched from my obscure corner in this great city the Titanic combat at present being waged in your columns, and much as I sympathise with Dr. Taylor's good intentions, I must confess that it seems to me the honours of the contest fall to Dr. Walsh. May I put the matter into what I conceive to be a logical nut-shell? Dr. Taylor has laid down a universal affirmative proposition—artificial prevention is anathema under all circumstances. You have received letters from two correspondents—"A Country Practitioner" and "A Poor Curate's Wife." These letters give concrete examples of particular cases which appear (to me) to conflict with Dr. Taylor's proposition. Will Dr. Taylor tell us, without circumlocution or qualification, whether:

(a) "Country Practitioner" (to whom a wife was practically a necessity) and "Poor Curate" (whose marriage certainly relieved him from the sin of committing adultery in his heart) did wrong to marry?

(b) If they did right, or, at any rate, finding themselves married at the present time:—



1. Should they seek to bring as many children as possible into the world?

2. Should they use artificial means to prevent or limit conception?

3. Should they persistently violate their natural instincts and abstain from doing what marriage (*vide* the opening sentences of the marriage service in the Prayer-Book) was ordained for?

If Dr. Taylor will be good enough to answer these questions I for one shall respect his motives, even if I do not approve of his judgment.

I am, Sir, yours truly,

QUALIFIED ASSISTANT.

Glasgow, August 20th, 1904.

#### EXPERIMENTAL TREATMENT OF CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Skene's Keith's article recently published in your columns gives an excellent summary of the present position with regard to the treatment of cancer, although, from my point of view, he is too pessimistic with regard to the future possibilities of radio-active methods. I am somewhat surprised, however, to find that Dr. Keith has omitted to publish full details of his method. He merely states generally that he has obtained good results from the hypodermic administration of certain substances. The omission of this particular information in an article published in a scientific journal must clearly have been due to an oversight. It is inconceivable that a gentleman of Dr. Keith's standing could knowingly have violated one of the most stringent traditions of professional conduct. Meanwhile, we are all most anxious to know what is the substance that in Dr. Keith's hands has relieved the sufferers from a terrible malady.

I am, Sir, yours truly,

Bexhill, August 16th, 1904. DUNS SCOTUS.

#### EPIDEMIC DIARRHOEA AND DIRTY FEEDING-BOTTLES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—During the past three weeks we have had many cases of diarrhoea and vomiting occurring in children, mostly between the ages of one and three years. I think that we are too prone to attribute these attacks to the addition of preservatives to milk, when possibly, by personal investigation, we might discover a simpler cause. During the past week I have seen seven cases of sickness and diarrhoea occurring in children aged from six to eighteen months. In no fewer than five cases an examination of the feeding bottle revealed the cause. The bottle itself was in a filthy condition, and the milk curdled in three cases. In two cases in which bottles with a long rubber tube connected the bottle with the teat, although the milk in the bottle was perfectly sweet, the tubing stank horribly, and thus the milk, on passing through, became contaminated. A preliminary purge and careful supervision of the bottles ended in rapid recovery. It would be an excellent step towards checking these epidemics of diarrhoea in infants if we could (1) Abolish the use of the feeding-bottle with long septic rubber channels for the conduction of the milk; (2) if we could impress upon all mothers the necessity of thoroughly cleansing the bottles after each feed. In two of the cases the tubing was absolutely black with flies, which doubtless aided the contamination. I think in the present day we are too apt to pass over the more common causes of disease, attributing it to some cause which is uppermost in the public mind through articles in the lay press.

I am, Sir, yours truly,

S. J. ROSS, M.D.

Bedford, August 22nd, 1904.

#### Royal Colleges of Physicians and Surgeons in Ireland.

THE preliminary examination for the Conjoint Diplomas of the Royal Colleges of Physicians and Surgeons in Ireland is fixed to take place on Monday, September 26th. Entrance forms and medical students' guide now ready.

## Obituary.

### SURGEON-MAJOR GENERAL TIPPETTS.

SURGEON-MAJOR GENERAL A. M. TIPPETTS, late of the Army Medical Service, has died at Southsea at the age of seventy-two. He qualified as a member of the Royal College of Surgeons in 1853, and joined the Medical Service of the Army as an assistant surgeon in April, 1854, serving in the Eastern campaign of that and the following year with the 7th Fusiliers. He took part in the affair of Bulganac, in the battles of Alma and Inkerman, and in the siege of Sebastopol, for which he had the medal with three clasps and the Turkish medal. As a surgeon-major he also took part in the Afghan War of 1878-80, accompanying the expeditions into the Bazar and Hissarik Valleys, for which he was mentioned in despatches and received his second medal. He became deputy surgeon-general in November, 1884, and retired in April, 1892, as a surgeon-major-general. Major-General Tippetts had been in receipt of a distinguished service reward since October, 1901.

### MR. D. A. HUGHES, M.R.C.S.

As the Great Western 12.15 train was about to leave Barmouth Junction one day last week, Mr. D. Arthur Hughes, a well-known medical practitioner at Barmouth, was observed to be running to catch the train. He reached a carriage-door and fell exhausted. He was put into a compartment, but when the train arrived at Barmouth life was pronounced to be extinct. Deceased held the post of Medical Officer of Health for the united districts of Barmouth.

## Literature.

### ANDREWES' DISINFECTATION AND STERILISATION. (a)

THIS work, the author tells us, is primarily intended for nurses and for medical men who have had no opportunities for systematic bacteriological study. "The book is written for those who know no bacteriology, but who need sufficient acquaintance with its principles and methods to be able to understand what they are doing when they attempt to carry out processes of disinfection." We consider that the author has succeeded in carrying out this aim, that the book is a timely contribution to science, and should appeal to those who have to carry out disinfection practically.

The work is divided into two parts, the first of which is comprised in ten lessons, of which the first is introductory and deals with the nature of bacteria, yeasts, and moulds, the second with the growth of bacteria and their distribution in Nature. Following this is an account of the chemical activities of bacteria and their power of producing disease. The fourth section deals with cultivation in artificial media, and section five deals with the thermal death-point of bacteria.

Disinfection by chemicals is considered in section six, and the two following sections are concerned with aerial disinfection and the sterilisation of fluids, and disinfection in surgery and midwifery. Sections nine and ten contain accounts of the nature of contagion and the various specific bacteria.

In Part II we have an excellent account of exercises and demonstrations of a highly valuable and practical character. In the section dealing with disinfection by heat the author explains the difficulty of disinfecting large masses of tightly-packed material, such as horse-hair, and mentions that some steam disinfectors have an arrangement whereby the air is exhausted from the material to be disinfected before the steam is admitted. The importance of this is not by any means clearly explained, as the removal of the air is of the greatest consequence, and, in fact, makes all the difference between the effective action or otherwise of a steam disinfectant. The Washington Lyon Disinfectant is illustrated, but the Thresh and the Equifex types are not, though they both possess the advantage that the

(a) "Lessons in Disinfection and Sterilisation." By F. W. Andrewes, M.A., M.D. Oxon., F.R.C.P. Lond., D.P.H. Cantab. Pp. 292, with 31 illustrations. Price 3s. net. London: J. and A. Churchill.

residual air is removed to a degree seldom attained by the Washington Lyon machine as ordinarily used.

In section six, disinfection by chemicals is considered, and the author very rightly insists on the necessity of a *given strength* and a *given time* for any particular chemical to be able to kill bacteria.

In fact, the whole of this section shows the most careful consideration, and should be read several times by the student of disinfection. We would specially commend (on page 89 *et seq.*) the paragraphs dealing with the criteria by which a disinfectant should be judged for practical purposes.

Pages 190-198 contain an excellent account of chemical disinfection, and the student who desires to follow up this most entrancing and important subject can find full details to guide him in the classical work of Rideal and Ainslie Walker, who have now succeeded in placing this difficult subject on a proper footing.

Dr. Andrewes' work is commendably free from quotations of contradictory experimental work on the germicidal action of various chemicals and proprietary articles, which are usually found to the perplexment of students.

The experiments on testing the power of disinfectants, described by Dr. Andrewes, are well detailed, but it may be doubted whether the organisms mentioned (*Staphylococcus pyogenes aureus* and *Coli communis*) are so suitable as *Bacillus typhosus*.

The book concludes with practical tests of disinfection, the testing of filters, &c., and we are satisfied that it meets a need which is a real one, namely, while moderate in price and simple in language, it affords an intelligent explanation of the why and wherefore of the problems of disinfection in general.

It should appeal in particular to practitioners in the country and to hospital nurses.

#### GALBRAITH ON EPOCHS OF WOMAN'S LIFE. (a)

THE four epochs discussed in this manual are maidenhood, marriage, maternity, and the menopause. It is a little difficult to determine the precise class of reader for whom the book is intended. Much of it consists of sensible advice which all women might with profit read and follow; on the other hand, a good deal is more suited to the medical than to the lay reader, with regard to both the technical character of the phraseology and to the nature and extent of the subjects treated of. The best section of the book is that on maternity; the least satisfactory is that on marriage. The authoress has evidently set out with the intention of inculcating higher ideals in the married life, and she points out the disastrous effects of excesses. There is no doubt that it is of the greatest importance that women should know more than they generally do about the ethics of the marriage state, and we cannot therefore but commend the authoress' intention; but this section would be improved if it were considerably condensed. We could wish that the authoress would somewhat recast the book, so as to make it frankly a book for the ordinary woman rather than for the medical woman, omitting at the same time much of what we must regard as unnecessary detail.

#### AIDS TO SURGERY. (b)

THIS book, which is one of the Students' Aids Series, is intended as a help for students preparing for examinations. We can strongly recommend it to the busy student for this purpose, for it is complete, thoroughly up to date, and the whole subject is condensed into a sufficiently small volume to fulfil its object without at the same time omitting anything of importance. The only point we can take exception to is the paragraph on actinomycosis, where the author conveys the impression that it is not a dangerous disease, for he says: "Large doses of potassium iodide, up to one drachm doses three times a day, for prolonged periods, will cure

(a) "The Four Epochs of Woman's Life: a Study in Hygiene." By Anna M. Galbraith, M.D. Second Edition. Philadelphia: Saunders and Co. 1903.

(b) "Aids to Surgery." By Joseph Cuning, M.B., F.R.C.S. Eng., Senior Resident Medical Officer, Royal Free Hospital, Pp. 394. Price 4s. 6d. London: Bailliere, Tindall and Cox. 1904.

these cases. In addition, if the sinuses are in a position where vigorous scraping can be done the process of cure is hastened."

#### WATSON'S EXAMINATION OF THE URINE. (a)

THIS little book is intended for nurses; the author says:—"The examination of the urine is not of necessity required of the nurse, but it is advisable that she should have an elementary knowledge of urine testing, since she can often put such knowledge to use and assist thereby the doctors under whom she is working."

The book is divided into three parts, the first gives an elementary knowledge of the organs which are concerned in the excretion of urine; the second deals with the physical characters in health and disease; the third with the collection and examination of the urine. The various tests are described simply and clearly, and a table is given showing the more important characters of the urine in some of the commoner diseases. The book is one which should prove a useful addition to the nurse's bookshelf.

#### BROWNE AND STEVENSON ON SQUINT IN CHILDREN. (b)

THIS little volume is an interesting and thoughtful contribution to the subject of convergent strabismus in childhood, and will repay perusal. The authors strike emphatically the true note in the preface, where it is said, "That which has borne the test of years, and is well established, is of more value in practical medicine than yesterday's inventions, which may be failures." Nothing could be truer of much of the so-called medical advance in the present day than this. There is the feverish rush to bring out "hall-baked" theories, and to introduce novelties in ideas and practice, merely for the sake of the notice which they may attract. On the other hand, it is nowadays but seldom that a well-digested contribution to medical literature, based upon the past experience of many years, and enriched with valuable suggestions, comes under the notice of the reviewer. In this category, however, the volume before us should be classed. The scientific etiology and treatment of this deformity have only of late received the attention which their importance deserved, mainly, no doubt, on account of the good results which the empirical method of treatment, introduced by Dieffenbach, of dividing the internal rectus, were instrumental in obtaining. That something was wrong in this form of treatment, however, was often in earlier days proved by the subsequent divergence which ensued as the result of the operation. The tendency in the present day is to avoid operative interference in case of convergent strabismus in children as much as possible, and in this book the reasons for this plan of practice and the methods by which it can be accomplished are clearly and convincingly laid down. To general practitioners, by whom, no doubt, the early stages of convergent strabismus are frequently first seen, this book should prove invaluable for the sound advice it contains on the subject, but ophthalmic surgeons also will find in it hints here and there which will repay them for its perusal.

#### JULER ON OPHTHALMIC SCIENCE AND PRACTICE. (c)

IN this new edition—the third—of his work, the author informs us that the text has been revised, but he does not point out, for the assistance of the reviewer, in which special directions additions and improvements have been effected. We observe that he still retains the obsolete expression "strumous," and speaks of "strumous" keratitis. Inasmuch as the word "strumous" has now no significance as a systemic

(a) "The Examination of the Urine." By J. K. Watson, M.D. Edin., M.B., C.M. Pp. 30. London: The Scientific Press, Limited.

(b) "Squint Occurring in Children: an Essay." By Edgar A. Browne, F.R.C.S. Edin., assisted by Edgar Stephenson, M.D., M.Ch. Aberd. London: Bailliere, Tindall and Cox. 1904.

(c) "A Handbook of Ophthalmic Science and Practice." By Henry E. Juler, F.R.C.S. With Illustrations. Third Edition; Revised and Enlarged. London: Smith, Elder and Co. 1904.

condition in general medicine and surgery, how can it be correct to use it in the special departments of our art? The so-called "strumous" keratitis is merely phlyctenular keratitis, aggravated by a septic condition of the conjunctival sac, which is the common feature of "poor and ill-fed," and consequently neglected, children. In the operation of tattooing the cornea, the author recommends the use of epilation forceps for fixing the globe. Epilation are certainly better than fixation forceps, but it is much better to use no forceps at all, the fingers being all that are necessary for the purpose. Detailed criticism, however, is superfluous in respect to a work whose popularity has been proved by the fact that it has reached a third edition. We can cordially recommend this handbook as a useful, practical guide to ophthalmic science; it represents much matured experience on the part of the author, and the present edition has been enriched by some excellent plates, illustrating the normal and pathological histology of the eye, contributed by Mr. George S. Keeling in an appendix.

## Medical News.

### West London Medico-Chirurgical Society.

The following gentlemen have been elected officers and members of Council of this Society for 1904-1905:—  
 President: Mr. C. M. Tuke.\* Vice-Presidents: Mr. C. B. Keetley, Mr. W. P. Barrett, Dr. G. H. D. Robinson, Mr. J. R. Lunn, Dr. E. Furniss Potter, Dr. E. Bromet,\* Dr. G. P. Shuter,\* Mr. H. Webb,\* Council: Mr. R. Pollock, Dr. A. M. Ross Sinclair, Mr. G. A. Garry Simpson, Mr. Percy Dunn, Mr. McAdam Eccles, Mr. E. P. Paton, Dr. A. Saunders, Dr. A. J. Rice Oxley, Dr. J. A. Mansell Moullin,\* Dr. A. Morrison,\* Dr. A. E. Russell,\* Dr. C. Buttar.\* Treasurer: M. T. Gunton Alderton. Secretaries: Dr. Andrew Elliot, Dr. W. H. Walter.\* Librarian: Mr. H. W. Chambers. Editor of Journal: Dr. Leonard Dobson. Editorial Secretary: Mr. J. G. Pardoe. \* Did not hold similar office last year.

### Chloroform Fatality.

A WOMAN, aged thirty-three years, was admitted to the Dalston Hospital, London, last week suffering from appendicitis. Two and a half drachms of chloroform had been administered previous to operation, when she died. After death she was found to have fatty degeneration of the heart.

### Sanitary Reorganisation for the Army.

SIR GILBERT PARKER last week asked the Secretary of State for War whether a scheme for sanitary organisation had yet been prepared for the army or proposed by the Medical Advisory Board; if so, whether there was included in it the sterilisation of all fluids employed as drinks at manoeuvres, on service abroad, and during active service, and by what means this sterilisation was to be secured; whether steps had been taken to secure the instruction, practical training, and examination of non-medical officers of all ranks, in their respective units or commands, in methods of camp sanitation, especially with a view to the prevention of enteric fever, dysentery and cholera; and whether, after such training and examination, the comparative responsibility of such non-medical officers for the occurrence of these diseases in their respective commands or units was to be recognised. Mr. Bromley-Davenport, replying for the Secretary of State, said that the Board recommended the appointment of special sanitary officers to army corps and commands, and there were eleven of these appointments at home and eight in Egypt and Colonies, in addition to the five already existing in India. Instructions regarding the sterilisation of all fluids employed as drinks which are applicable to manoeuvres, service abroad, and active service had been included in the manual of combined training; heat, and in some cases filtration, were the means recommended. Lectures were regularly given to cadets at Sandhurst and Woolwich, and a more advanced course in military hygiene was provided for officers at the Staff College. Instructions in hy-

gienic matters were also given by the specialist sanitary officers. The regulations were also being revised in the direction of devolving more responsibility upon non-medical officers in the supervision of sanitary services in barracks and camps.

### The Plague.

THE following telegram from Lord Milner was received at the Colonial Office on August 6th:—"My telegram of July 31st, No. 211. Plague return should have been no change. As there has been no change since July 9th, no further telegrams will be sent unless recrudescence occurs." A further telegram from Lord Milner, received on August 13th, says:—"Transvaal is now officially certified as clean of plague in terms of Venice Convention." The following telegram has been received at the Colonial Office from Sir M. Nathan, Governor of Hong-Kong:—"Five cases of plague, five deaths, for the week ending August 13th."—*Times*.

### Wills and Bequests.

SIR JOHN SIMON, K.C.B., of 40 Kensington Square, formerly consulting surgeon at St. Thomas's Hospital, left estate, so far as can at present be ascertained, valued at £26,635 gross, with net personality £26,545. Subject to numerous annuities to relatives and friends, and the life interest in a special trust fund of his adopted daughter, the testator left the ultimate residue of his estate to St. Thomas's Hospital, and should the income of the said special trust fund exceed £300, then the surplus is also to be paid to St. Thomas's Hospital.

### Forty Thousand Deaths from Cholera.

NEWS from the cholera districts of Persia is reassuring. The disease has wholly disappeared in many places, and is losing its malignancy in all. But in Teheran between twenty and twenty-five thousand deaths occurred during six weeks, and in the environs about the same number. At present the mortality from that cause in the capital is computed at thirty-five daily, whereas the environs are exempt from the scourge.—*Daily Telegraph*.

## PASS LISTS.

### Royal College of Surgeons, England.

THE following candidates, having passed the necessary examinations, have been admitted members of the College. The names are arranged alphabetically: F. Alcock, E. F. Alford, H. R. Allingham, J. Ayles, F. Barnes, C. E. Bartlett, J. E. L. Bates, L. Bathurst, J. H. Bletsoe, H. G. W. Beckett, H. J. Brewer, F. M. Boclet, J. Bowen-Jones, F. A. Brodribb, E. M. Brown, F. M. Bulley, W. Byam, P. D. MacI. Campbell, T. W. Chaff, J. R. A. Clark-Hall, C. Colmer, G. H. Colt, P. C. Coombes, H. Cooper, W. F. Corfield, W. I. Cumberlidge, F. W. Daniels, W. B. Davy, W. R. E. Drawbridge, E. P. H. Dudley, H. D. Duke, H. E. Dyson, W. S. Edmond, N. C. Fletcher, T. H. Fowler, H. Frankish, J. D. Galloway, H. T. George, S. H. Gibson, H. J. Gibbs, D. R. Gilder, J. L. Gilkes, J. W. F. Gillies, F. G. Goble, R. E. G. Gray, M. Greenwood, P. Gully, C. M. Halsall, J. M. Hamill, R. O. Handcock, A. E. Hay, A. L. Heiser, J. W. Hele, F. C. Hepburn, G. W. Heron, E. C. Hughes, H. Irving, S. D. Jacobson, T. Jays, H. A. Kisch, H. H. Jenkins, O. S. Kellett, W. R. Kirkness, J. L. Lawry, H. Leach, H. C. Lees, G. M. L. Lester, T. Lewis, E. G. R. Lithgow, J. H. McAllum, E. J. C. McDonald, G. H. McLaren, J. B. McVail, H. T. Mant, P. J. Marett, W. N. May, W. O. Meck, R. Milne, E. L. Moss, R. C. Mott, M. J. Motttram, B. N. Murphy, F. Neale, H. Nicol, S. A. Owen, G. R. Painton, W. F. Peach, E. G. Perodeau, E. E. M. Price, T. P. Puddicombe, C. E. Reynolds, R. I. Ritchie, T. H. F. Roberts, G. C. F. Robinson, W. E. Robertson, E. J. H. Rudge, A. P. Salt, H. B. Scott, T. Sanders, S. G. Scott, P. H. Seal, A. W. K. Straton, K. Takaki, A. Withead-Smith, H. M. Thomas, H. S. Turner, M. K. Varughese, W. T. Wallace, H. B. Walters, C. S. White, H. T. M. Wilson, K. S. Wise, and S. C. Yin.

## 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.

**M.D., Vict.**—The Annual Report of the Reg.-Gen. for England and Wales for 1902 is now published and in it you will find the information you require. The births registered in the two countries for that year were 940,500, equal to an annual birth-rate of 28.5 per 1000 of the population. The figures are identical with those of the preceding year, but show a fall of 1.1 when compared with the ten-yearly average for 1892-1901.

**DR. FITZGERALD.**—The finding of the Court was in our opinion more than justified. The thinking medical man should find no little food for reflection in the conflict of scientific evidence. One set of witnesses swear that disastrous effects are produced on lower animals by the administration of a particular drug. Another set of experts testify that the ordinary medicinal dose of that substance is far larger and that it is administered over long periods. Can any candid practitioner seriously defend the use of such a remedy under these conditions? Yet precisely similar remarks apply to various drugs in daily use.

**M. B. (Worcester).**—Is thanked for his letter and appreciation of policy. The diminishing birth-rate as a subject for discussion is looked on askance by most of the medical journals. It nevertheless involves the very foundations of our social system. There is no reason why the medical profession should not investigate in a calm and scientific spirit, the laws that determine the rise or fall of the national birth-rate. Hardly any subject could be of greater definite and vital importance to the community.

### A DAILY MEDICAL JOURNAL.

A **LAY** contemporary announces that a daily medical paper, which is to be made up of six pages of ordinary newspaper size, is to appear in New York, and that a first edition of 100,000 copies has been already subscribed for. What a rich feast of symptoms that 100,000 must be looking forward to! Strangely enough, the chosen home of the patent medicine is not the first country to possess a medical "daily," America having been preceded on this occasion by Italy, where the "Riforma Medica" is published.

**A. B. C.**—We fear there is no other course open to our correspondent but to pay the tax.

**MR. E. WATSON.**—The city which has the largest population next to London is New York, and not Paris as is generally supposed. For further information on populations, see reply to Mr. R. Stevens in our last issue.

### NATIONAL DEGENERATION.

As a contribution to the moot question of the degeneracy of our race Mr. Walter Burns of Belfast writes us that he is now 80 years of age and has "neither gout, rheumatism, pain, nor ache. He can walk as quickly as ever, and has neither shake in his hand nor wrinkle in his skin." He asks "how can the race be anything but degenerate when the large majority of men and women both drink alcohol and smoke tobacco?" He does neither, and says his legacy to his countrymen for health is, "take exercise in the open air every day wet and dry, keep the feet and body dry and the head cool; no heavy dinners, and no heavy suppers, and no alcohol or smoking, and with a fairly good constitution there need be no fear of national decay."

[Probably the possession of a sound constitution has more to do with the robust health of our correspondent than even his abstinence from alcohol and tobacco. We can point to many men of his age equally robust, although non-abstainers, having pursued a simple and healthy course of living.—ED.]

## Vacancies.

**Devon County Asylum.**—Assistant Medical Officer. Salary commencing at £125 per annum, with board and lodgings. Apply to the Medical Superintendent, Asylum, Exminster.

**Carlisle Non-Provident Dispensary.**—Resident Medical Officer. Salary £150 per annum, with apartments (not board). Applications to the Honorary Secretary, G. A. Lightfoot, Esq., 23 Lowther Street, Carlisle.

**Stockport Infirmary.**—Junior Assistant House Surgeon. Salary £140 per annum, with board, washing and residence. Applications to the secretary.

**Macclesfield General Infirmary.**—Junior House Surgeon. Salary £150 per annum, with board and residence at the Institution. Applications to the Chairman of the House Committee.

**Rotherham Hospital and Dispensary.**—Senior House Surgeon. Salary £110 per annum, with board, lodging, and washing. Applications to the Secretary, E. S. Baylis, 19 Moorgate Street, Rotherham.

**Hampstead General Hospital.**—Resident Medical Officer. Salary £120 per annum, with rooms, coals, and gas. Applications to George Watts, Secretary.

**Aberaman, near Aberdare.**—A fully qualified Medical Man to take Charge of a large Colliery District Practice. Salary £400 per annum, with a free house, coal, assistants, dispenser, drugs, &c. No private practice allowed. Applicants must be married. Applications to the Secretary, James Phillips, 10 Pleasant View, Godre Aman, Aberdare.

**Lancaster Royal Infirmary.**—House Surgeon. Salary £100 per annum, with residence, board, attendance, and washing. Applications to the Hon. Secretary.

**Birkenhead and Wirral Children's Hospital.**—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to E. H. Tilby, Hon. Sec., 69 Temple Road, Birkenhead.

**Open-air Sanatorium for Consumptives, Limpley Stoke, near Bath.**—To be opened November next.—Resident Medical Officer. Salary £200 per annum, with annual increment £20 to £200. Experience in Sanatorial Treatment essential. Applications to "Chairman," N.A.P.O., 84 Park Street, Bristol.

**County of London.**—Woman Inspector in the Public Health Department under the Midwives Act, 1902. Salary £150, rising by annual increments of £15 to a maximum of £250. Applications on the official form, to be obtained from the Clerk of the London County Council.

## Appointments.

**MONTGOMERY, ALEXANDER, M.B., B.S.R.C.I.** Medical Attendant to the Royal Irish Constabulary for the C District of Belfast.

**MURRAY, H. L., M.B., B.S. ABERD.** House Surgeon to the Liverpool Hospital for Women.

**NORMAN, A. S., L.R.C.P. Lond., M.R.C.S. Eng.** Certifying Surgeon under the Factory Act for the Havant District of the county of Southampton.

**PERRY, S. HERBERT, M.D. Lond., M.B. Ch.B. Firm., M.B.C.P.** Assistant Physician to the General Hospital, Birmingham.

**RICHARDS, W. HUNTER, M.B., M.S. Durh., M.R.C.S. Eng.** Honorary Consulting Obstetric Physician to the Fowey (Cornwall) Cottage Hospital.

**SMITH, WILLIAM, Medical Officer** for the Hawkesbury, Alderly, Badminton and Acton Turville districts of Chipping Sodbury (Gloucestershire).

**SOPER, GERALD MORGAN, L.R.C.P. Lond., M.R.C.S.** Medical Officer and Public Vaccinator for the Dartmouth and Dittisham Districts of Totnes (Devon).

## Births.

**HULKE.**—On August 17th, at Ivy House, Walmer, the wife of Sydney B. Hulke, F.R.C.S., of a daughter.

**STABB.**—On August 19th, at Harleston, Torquay, the wife of W. W. Stabb, M.D., of a daughter.

**VAUGHAN.**—On August 18th, at St. Petroc, Coalville, Leicestershire, the wife of A. W. Vaughan, L.R.C.P., L.R.C.S., of a daughter.

## Marriages.

**HEAL—TODDUNTER.**—On August 20th, Ambrose Heal, jun., of The Fives Court, Finner, to Edith Florence Digby Toddunter, elder daughter of Dr. Toddunter, M.D., of Orchardcroft, Bedford Park, Chiswick.

**LEGG—MACK.**—On August 18th, at St. Giles, Shermanbury, Thomas Morison Legge, M.D., to Norah Elizabeth, second daughter of J. A. Mack, of The Grinstead, Partridge Green, Sussex.

**STEELE—PARDON.**—On August 17th, at St. Clement's Boecombe, Hants., Charles Hallowell Steele, youngest son of William Stott Steele, M.D., of St. Mary's Church, Devon, to Elsie Joyce Pardon, youngest daughter of John Pardon, Esq., of Culvers, Boecombe, Hants.

**TRUBSHAW—PERKINS.**—On August 18th, at St. Peter's, Pwllheli, Wilfred Trubshaw, Assistant Prosecuting Solicitor to the Corporation of Liverpool, eldest son of Alfred Trubshaw, M.R.C.S., of Pendre, Mold, to Bessie Andre, third daughter of Walter Edward Perkins, J.P., of Bodegoes, Pwllheli, and The Grange, Astwood Bank, Worcestershire.

**TURNER—DENSHAM.**—On August 18th, at St. Luke's Church, Grayshott, Surrey, Francis John Turner, B.A.M.C., son of the late Rev. H. J. Turner, to Mary Theodora, youngest daughter of Benjamin Densham, of Hindhead, Surrey.

**USHER—COMYN.**—On August 18th at St. Paul's Church, Southsea, Lieut. Wm. A. Usher, R.N.R., H.M.S. Apollo, eldest son of the late James Usher, solicitor, Florence Villa, Lurgan, Ireland, to Sophie Honoria, only daughter of Surgeon-General J. S. Comyn, R.A.M.C. (retired), of Woodstock, Galway, and of 21 Ashburton Road, Southsea.

## Deaths.

**ASHER.**—On August 21st, at the Nursing Home, Warrington Lodge, Philip, elder son of the late Asker Asher, M.D., aged 85.

**HENSMAN.**—On August 18th, at Northdown, Margate, Baby, second daughter of Lieutenant-Colonel William Hensman, R.A.M.C., of Cannesfield, Taunton, aged 26.

**STEWART.**—On August 18th at Dunmurry, Sneyd Park, near Clifton, Glo's, Hamilton Stewart, younger son of James Stewart, B.A., F.R.C.P. Ed., of the same address.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, AUGUST 31, 1904.

No. 9.

## Original Communications.

### THE PREVENTIVE TREATMENT OF SCARLET FEVER

BY ISOLATION (AGGREGATION) HOSPITALS.

By HUBERT E. J. BISS, M.A., M.D. Cantab., D.P.H.,  
Eastbourne;  
Late Assistant Medical Officer, Metropolitan Asylums Board.

#### PART I.

SCARLET fever is a disease of very wide prevalence in this country at the present day. There is no district, urban or rural, that does not suffer to a greater or less extent from its incidence. It is, then, only natural that the community should wish to take steps to rid itself of this malady, especially as it is generally regarded as a highly dangerous one. Some twenty-five years ago, after obtaining the best medical advice, certain towns erected hospitals for the special treatment of infectious diseases, scarlet fever being the one specially aimed at. The idea prevailed at that time that as scarlet fever was infectious by direct or proximal contact, removing the patients suffering from it to a building to which general access was barred would eradicate the centres from which the disease spread. By diligently practising this plan of treatment it was supposed that scarlet fever would either die out or become markedly less. Since the inauguration of this method, urged by the medical profession and pressed by the Local Government Board, nearly every sanitary authority has built a fever hospital. The country, therefore, has had considerable experience of its working, and it may not be out of place to look round at the results that have ensued. To those to whom truth is the prime object to be followed by sanitary as by every other science, it comes as a sad reflection that a proposal to this effect should meet with vehement opposition, but when three or four years ago Dr. Dean Marriott, of Nottingham, and Dr. Killick Millard, then Medical Officer of Health for Burton-on-Trent and now for Leicester, came forward with a good deal of evidence to show all was not going as well with the system as was generally supposed, and suggested more extended inquiry, their proposal was scoffed at. Since then from many quarters further evidence has been forthcoming, and at the present moment the necessity for an inquiry into the fever hospital system, as applied to the preventive treatment of scarlet fever, has been admitted by nearly all the leading organs of the profession, and by many societies of medical sanitarians.

But the demand, for such it really amounts to, has not been sufficiently unanimous to secure its object. To myself it seems a pity that this question should be regarded as polemical; it ought to be looked upon as a strictly scientific one, which if examined on strictly scientific lines must lead to fresh knowledge about a puzzling disease. My present contribution to this debate aims only at suggesting some *prima facie* considerations, first, as to why scarlet

fever *en masse* might be expected to be little amenable to hospital treatment, and, secondly, as to certain obvious disadvantages of the system. I shall confine my remarks strictly to the subject of scarlet fever, for that is the disease which the hospitals were in the main erected to cope with, and which occupies the bulk of their beds. It may or may not be that certain of the arguments apply equally to some of the other infectious diseases, but of them I do not wish to speak. At the same time, it must be remembered that it by no means necessarily follows that because a certain plan of treatment has been successful or unsuccessful with one disease, that it will be successful or unsuccessful with another. Every disease has its own characteristics *en gros*, just as it has *en détail*, and the preventive means appropriate to each will often vary as much as the clinical treatment. No one, for instance, would be found to agree that hospital treatment had been effectual in "stamping out" diphtheria, for it is notorious that that malady has increased by leaps and bounds during recent years. Small-pox, on the contrary, seems to a certain extent to be amenable to institutional influences, but here we have the question complicated by the protection afforded by vaccination.

In writing of an epidemic affection it is usual and convenient to speak of the disease as though it had a separate corporate existence; thus we speak of scarlet fever, diphtheria, and so on, attacking people, invading towns, giving rise to mortality, much as we would of an army or a destroying angel. This is neither correct nor scientific. No disease exists or can exist apart from the patient; the subject in whom the disease manifests itself furnishes by means of the tissue changes wrought in him the *materies morbi* of the disease. But so long as we bear in mind that such is the case, we can speak of the disease objectively considered as "scarlet fever," "diphtheria," or what-not, without violating our pathological convictions. Practically, too, we gain by avoiding cumbersome circumlocutions. Another point I should like to make before passing to my principal thesis: custom and misconception have sanctified the term "isolation hospital" to our institutions for fever patients; common sense and accuracy cannot lend their cachet to the description. An isolation hospital, a hospital where the patient is isolated, does not exist in this country. The fever hospital is an institution where patients are segregated from their fellows and aggregated together, and as it seems to be this very aggregation (want of isolation) that is responsible for much of the mischief of the system, it does not seem fair to speak of an isolation hospital when we really mean an aggregation hospital. There is a real, essential difference.

Now, in order to assess the effect of the aggregation hospital as a factor in scarlet fever incidence, it will be necessary to consider in some detail what is meant by this scarlet fever; what are the characters of the disease as met with when it affects communities and when it affects individuals; we must look at its history, its natural course, and its present condition. These points I should like to review, and further to speak of the necessarily entailed evils of the aggregation policy, but the main topic—the effect of hospital treatment

as a preventive of scarlet fever incidence—I shall leave to Dr. Killick Millard, who has worked so assiduously and energetically at the subject.

I would begin, then, by taking a backward glance over the course that scarlet fever has followed since it appeared in this country. Here, however, one is faced by a great practical difficulty, and one not without its significance; I mean the impossibility of distinguishing scarlet fever from diphtheria and other throat inflammations in the early accounts that have come down to us. We may form theories, hazard conjectures, promulgate views, but in actual fact it is not possible to speak with certainty. The Greek *κυνδύχη*, the Latin "angina," the Spanish "garrotillo," the American "throat distemper," the Irish "plague of the throat," the mediæval "pestitis gutturosa"—all seem in one description to point to scarlet fever, in another to diphtheria, in a third to tonsillitis. Now, a full-blown scarlatina rash is a disease phenomenon at once obvious and striking; the contrast between the rosy, angry skin of scarlet fever and the pale, waxy cuticle of diphtheria would immediately arrest the most casual observer's eye. How, then, does it happen that when we seek to penetrate into the true nature of an epidemic of throat disease as described by the older pyretologists we are lost in an impenetrable jungle?

Is it the physicians were careless and stupid, or is it that two, aye, and three, diseases were often mingled in the same outbreak? Personally, I incline to the latter view, and it is one taken by an epidemiologist of the eminence of Creighton. Doubtless, the clinical manifestations of the two diseases were not at all clearly distinguished, for even after Bretonneau had established the leading features of diphtheria he was forced to protest against his chosen name being used indiscriminately for all diphtheria-like appearances of the throat. It is, however, difficult to read accounts such as those given by Dr. J. Wall and Dr. J. Johnstone of the epidemic of throat-disease at Kidderminster betwixt 1748-50 without the conviction being borne in on one that this outbreak was not a uniform, unalloyed one, but that both diseases played a rôle in it, scarlet fever, perhaps, the more prominent one. The same holds good for many other epidemics, such as the morbus strangulatorius of Starr, in Cornwall, in 1750, the throat-disease of Hexham, in Plymouth, in 1751, the ulcerated or malignant sore throats described by Fothergill, Fordyce, Withering, and others. Hexham, for instance, is quite clear as to the sloughing of the throat and the rash, but he gives a vivid description of the tracheal casts spat up by the patients—an event that never happens in scarlet fever *pur et simple*. Far from this view being an unreasonable one, in the light of what we now know of the cross-infection of patients in hospital, it is an eminently reasonable view. It is probably also the right one. There is another fact that is also most striking in reading the history of scarlet fever, and that is the remarkable variations in the severity of the outbreaks, and even of the same outbreak at different times in adjacent places. Naturally enough the mild epidemics received less treatment at the hands of contemporary writers than the malignant ones, and it is safe to assume that in an age when the *cacothetes scribendi* had not the vogue that it enjoys at the present day, many a mild outbreak passed unrecorded. Still, this difference in type, as it is called, is sufficiently well established by what has come down to us to place it beyond doubt that far from the modern benignity of scarlet fever being an isolated phenomenon, it is quite *en place* with the behaviour of that erratic disease. Examples of malignancy are furnished by the outbreak at Kingston, in New England, in 1735, and the country districts of New Hampshire; in these places it carried off one-third to one-sixth of those attacked, whilst of the 1746 outbreak in Bromley-by-Bow it is recorded that "so many children died suddenly, some losing all and others the greater part of their families, that people were reminded of the plague." On the other hand, the epidemic at Chesham in 1788, described by Ramsey, "carried off but few considering the great numbers

affected by it," and the outbreaks in London, 1807-08 and 1814, are described as being "generally mild, presenting the eruption with slight sore throat." Again in the same epidemic the two types of the disease may be present side by side, as occurred, for example, in an outbreak related by Dr. James Sims in 1798. Much more often an epidemic of considerable malignancy was succeeded by years of wide prevalence of a benign form of the disease. Such a change of type is recorded by Dr. Levison in 1778. The very violent epidemic of scarlet fever which prevailed in London and the surrounding villages in 1777 abated in November, but was succeeded in the following year by a very mild type of the disease that affected many persons. In 1810-11 malignant scarlet fever scourged Nottingham and Debenham, but its virulence abated and remained in abeyance till 1831, though a mild form of the malady was common enough in the interval. The most clear and striking account of this variation in type is the well-known one we read of in Graves' "Clinical Lectures." In that classical work he tells us after the fearful epidemic in 1801-04 in Dublin, "although scarlatina epidemics recurred very frequently during the next twenty-seven years, yet it was always in a simple and mild form." In 1834 the disease again assumed virulent guise, and committed ravages similar to those of 1801. It is in this connection that Graves speaks those pregnant words which will bear quotation even once again. "In spite," says he, "of our boasted improvements, we have not been more successful in 1834-35 than were our predecessors in 1801-02." One cannot help reflecting—Are we any more successful in 1904?

Having seen, then, that it is the habit of scarlet fever to vary widely both in its prevalence and in its character, we may next consider what was the condition of this country with regard to the disease before the advent of the aggregation hospital. Now, after a generation of mild but widely disseminated scarlet fever, the middle of the nineteenth century was characterised by many severe epidemics, and it would hardly be too much to say that between 1840 and 1874 the country was scourged by the disease. The figures for each of the decennial periods 1841-50, 1851-60, 1861-70, and 1871-80 show great mortality from scarlet fever, the highest peaks being reached in 1848, 1858-59, 1863-64, 1868-70, and 1874. In the years 1863-74 scarlet fever was the cause of 4 to 6 per cent. of the deaths from all causes in England and Wales. 1863 was the year of highest mortality with 30,475 deaths, and 1874 the lowest (except 1868) with 24,922. Naturally, scarlet fever became greatly dreaded, and it is not in the least surprising that with this record well within the memory of living people the disease should be regarded as a pestilence to be combated by every available means. But the natural swing of the pendulum, particular virulence abating to give place to wide prevalence of the malady in benign form, took place after 1874, and from that date the mortality has been steadily on the decline—a condition of things that the well-informed epidemiologist could have foretold with no little certainty at the time. It has been claimed that this drop in the death figures was due to the introduction of the aggregation hospital, but this claim can hardly be seriously maintained; indeed, it is not made by the more responsible epidemiologists and medical statisticians. The change of type was, historically speaking, due at the time it set in, as similar changes had been due and had fulfilled their destinies time after time in past years. Moreover, this alteration was not confined to this country alone, but occurred about the same time in America, Germany, and Norway, where the aggregation principle has not been adhered to as it has in Great Britain. It is difficult to see how it can be thought that the establishment of a few hospitals in isolated centres could have affected the type of the disease in its general incidence, for it must be remembered that anything approaching general aggregation in hospital has only been attained during the



last fifteen years or so. The only possible way by which hospitals could reduce the total mortality of the disease would be by a vast superiority of hospital treatment over home treatment. In the absence of any specific treatment for scarlet fever it is not reasonable to attribute any change in mortality to any particular plan of treatment, especially as there is none for which such claim has been made. Comparative mortality figures for home and hospital treatment are difficult to obtain, and for various obvious reasons are open to great fallacy when they are obtained and compared. I have, however, calculated the scarlet fever death-rate for those removed to hospital and for those who remained at home, in London, for the five years 1898-1903. These figures are the largest available; the returns for towns of average size deal with so small a number of deaths that the transference of one or two cases from one column to another affects the percentage very considerably, and gives an erroneous idea of the significance of the factors involved. In taking the figures for London I have not included the cases admitted to the London Fever Hospital, which were few in number, and I have calculated the death-rates on the total admissions to the Metropolitan Asylums Board hospitals, instead of on half the sum of the total admissions, discharges, and deaths as ordered by the Registrar-General. This it was necessary to do in order to make the figures comparable with those of home-treated cases; the difference is very small, and such as it is would make for a higher rate for the hospital cases.

Year.	Notifications.	Hospital Death-rate.	Home Death-rate.
1898	16,894	4'11	1'51
1899	18,089	2'51	1'01
1900	13,800	2'99	1'43
1901	18,381	3'73	1'08
1902	18,252	3'53	1'28

I do not wish to press the significance of these rates unduly. They are subject to selective influences on both sides—the home and hospital; but I think it may fairly be said that they indicate pretty conclusively that there is no general therapeutical gain to patients treated in hospitals even under the very favourable conditions they enjoy in the Metropolitan Asylums Board's institutions. It is as unreasonable to attribute the fall in the death figures for scarlet fever to the institution of aggregation hospitals, as it is to attribute to the same influence the undoubted change in the degree of severity of attacks of the disease which occurred in the last quarter of the nineteenth century. The fall in the death figures is the direct reflection of the change in type of the disease, and both are natural variants in its epidemic history that have occurred wherever the disease has been prevalent for any length of recorded time. The question naturally arises—to what are these changes in the character of the disease due? why is it limited and savage here to-day, wide and benign there to-morrow? Every one of those influences that are supposed to affect the malignancy and benignity of diseases has been canvassed over and over again by epidemiologists, and the net result, honestly stated, is that no one knows. The mystery is just as deep as is that of the original *habitat* of scarlet fever. At the present day we find the disease principally manifesting itself in endemic form in the temperate zones, but it can, and has often, prevailed widely in the tropics. The virus, however, does not find so congenial a *milieu* in the hot and cold climates as it does in the temperate ones; consequently it is more firmly established in those districts of North America, Australia, and Europe which enjoy a mean temperature at neither extreme of the thermometer. But in these districts neither heat nor cold, dryness nor wetness, healthy surroundings nor unhealthy surroundings, richness nor poverty have been shown to exercise any influence on the type of the disease that prevails, or the class of society that it attacks. True endemic scarlet fever has a seasonal rise and fall, in England the maximum height of its curve being attained in the late autumn and the minimum

in early spring. Any help that might be expected from the study of this phenomenon is, however, negated by the paradoxical fact that the New York mortality curve is the inverse of the London one. Attempts to fix the responsibility for the character of scarlet fever outbreaks on this, that, or the other factor have so far been failures. Hirsch, after a critical inquiry, sums up the situation by saying: "We are completely in the dark as to the conditions that make scarlet fever epidemics assume a good or bad type." The same holds good with regard to the conditions that bring about scarlet fever prevalence. Beyond the fact that milk is a recognised agent in sometimes spreading the disease, and that scarlet fever is more common in the fall of the year, our knowledge of the factors that initiate scarlet fever outbreaks amounts practically to nothing. Every variation in the weather and every insanitary condition has been charged at some time or another with the responsibility of setting up epidemics of scarlet fever, but none of these has as yet been shown to be necessary or even determinative, either alone or in combination.

It is only just, then, to admit that whilst of the history and geography of scarlet fever we have a fair amount of information showing the disease to be a very variable one both as to prevalence and intensity, we know nothing of any value of the causes of these phenomena. When, therefore, we essay to fight the disease, we take up arms against a sea of troubles, and it is hardly rational to suppose that with so little information—and that so untrustworthy—of the causes of the malady we can hope to make any successful progress with its preventive treatment. The theory that by removing the personal element of infection we shall eradicate the chief propagating factor of the disease leaves out of account practical difficulties so momentous that it is hard to believe that the advocates of *en masse* removal to hospital could have had much personal experience of the clinical manifestations of scarlet fever. The whole essence of success in the aggregation policy, if it can ever be attended with success, is early and accurate diagnosis, and it is just this early and accurate diagnosis that is one of the most elusive features of scarlatinal infection. The fully-developed case of scarlet fever, with its throat and skin symptoms well marked, causes the average practitioner but little hesitation, but side by side with such cases, and independently of them, occur numerous others in which a little fever or malaise, a fleeting rash, or slight pharyngitis, is all the diagnostician has to guide him. The greater his range of experience the greater is his puzzle, and from the administration point of view he has to choose between certifying dozens of doubtful cases, or leaving half the scarlet fever ones he sees unremoved. Many cases are with our present apparatus undiagnosable, and yet we hear people speak of scarlet fever as if it were as distinctive and recognisable from other maladies as among warships a torpedo-boat is from a cruiser. In medical writings one sees it often stated that the scarlatina of Sydenham is the classical description of the disease, and one is left to deduce that something approaching finality was attained by that admirable physician. But Sydenham does not even mention sore throat as one of the symptoms, and he regarded the malady as a trivial complaint hardly worthy of the name of disease (*hoc morbi nomen, vix enim altius assurgit*)—fatal only through the too great assiduity of the medical attendant. The later writers—Trousseau, Graves, Watson—all recognise the multifarious varieties of scarlet fever, and the difficulty of determining the nature of those slight cases of illness which present no characteristic conjunctions of symptoms. Their *scarlatina latens* finds its modern homologues and congeners in conditions described under various names by various writers. In recent literature one finds *scarlatina sine eruptions*, *scarlatina apyretique*, *scarlatinette*, *ambulatory scarlatina*, *scarlatina minima*—all these terms used to designate those ephemeral attacks which, clinically, are merely interesting, but from the epidemiological point of view disastrous to any "isolation" system. They are perfectly definite,

indisputable occurrences, these attacks, thoroughly well known to an observer of the disease, but often only revealing their nature by collateral or circumstantial evidence. I need not detail their characters; sufficient is it to say that with no criterion to which reference can be made there is not a case of tonsillitis or of erythema of the skin of the chest, that one meets with in every day practice, of which one can say with certainty whether or not it is an instance of scarlatinal infection. Observation will sometimes help to solve the problem, but it has been one's experience time and again to have a suspected patient under daily supervision, and at the end of six or eight weeks to have to discharge him without any satisfactory diagnosis having been made. No system of isolation can afford to neglect these cases. They are as scarlatinal as the most severe attacks, and as instinct with infection. Without presuming any carelessness or want of skill on the part of the practitioner, it seems to me to follow necessarily that if scarlatina is to stand a chance of eradication by isolation, a prodigious number of cases of slight sore throat, of anomalous blushes of the skin, of ill-defined shagginess of the fingers, must be swept into hospital, or a large proportion of actual and potential sources of infection be left to stalk unrestrained through the land. Such a procedure is, of course, impracticable. It would entail imprisonment and serious loss to enormous numbers of persons not suffering from scarlet fever, but whose illness could not be diagnosed with certainty. Any system that seeks to eliminate the personal element in scarlet fever infection must rest for its success on the separation of all cases, or of such a large percentage that a very sensible reduction in the total number of infections would be apparent. Such can never be the case till the diagnosis has improved to such a point that practically all cases, however mild, are recognised and dealt with in hospital or at home. Till some new fact is introduced into our knowledge of the disease, it seems to me impossible to hope for any satisfaction in seeking to control scarlet fever by personal isolation. It is even doubtful in the light of its past history whether individual elimination is likely ever to be of much service as a prophylactic measure. It is axiomatic in most human affairs that the policy of shutting the stable-door after the horse has been stolen is futile.

## HOSPITAL ISOLATION AND SCARLET FEVER:

### THE STATISTICAL ASPECT.

By C. KILLICK MILLARD, M.D., D.Sc.,

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WHILST the question of the utility or otherwise of fever hospitals requires to be carefully looked at from every point of view, it can only be finally settled by appealing to statistics. It is well known, of course, that the use of figures may easily involve fallacies, and so lead to erroneous conclusions, but this is no argument against their legitimate use. As Dr. Newsholme has well said, "While so many are ready to say that 'anything can be proved by statistics,' but few realise that without statistics nothing can be proved, and that unless complete ignorance is to persist, even defective statistics must be used to the full extent of their value."

In the case of hospital isolation the problem specially lends itself to statistical consideration as all the essential data are obtainable. Thanks to compulsory notification, which has now been in force in most of our larger towns for at least ten years, and in many for a much longer period, we know, with approximate accuracy, the number of cases of scarlet fever occurring year by year. The estimated population for each year being also,

of course, known enables us to calculate the attack-rate per 1,000 population, or *prevalence* of the disease, so that differences arising from variations in population are eliminated. The death returns, which go back for a much longer period, enable us to calculate *mortality*, whilst the number of attacks and the number of deaths together yield the proportion of cases proving fatal, or *fatality*.

### METHODS OF USING STATISTICS.

Whilst the essential purpose of all statistics is comparison, there are two different methods of making comparisons applicable to the present problem. The first is to consider each town or district separately, comparing its condition with regard to scarlet fever since the policy of hospital isolation was started with what existed previously. The second is to compare towns with other towns which differ from them as regards the practice of hospital isolation.

The first method is a good one as far as it goes, but it has certain limitations. Thus, in very many towns compulsory notification only came into force simultaneously with, or subsequently to, the practice of hospital isolation, so that in these cases it is impossible to make any comparison as regards the relative prevalence of the disease. Then, in the case of mortality, although this is known for a sufficiently long period, we are met with this difficulty, that *everywhere the mortality from scarlet fever has been on the decline* owing to the change which has taken place in the type of the disease. It is now admitted that this change, from a very severe to a very mild type, has taken place quite independently of hospital isolation, for (a) the change set in about 1860-70—*i.e.*, before hospital isolation was thought of; (b) it has been quite as marked in towns and country districts which have never practised hospital isolation; (c) it has taken place in other countries, including those where hospital isolation is practically unknown.

Unfortunately these facts have only recently become recognised, (a) and many sanitarians, influenced no doubt by a very natural desire to justify the great outlay which the erection and maintenance of fever hospitals entailed, fell into the error of ascribing the reduction in scarlet fever mortality which they observed in towns where hospital isolation had long been practised to result of such hospital isolation.

There can be little doubt that in this way the belief was propagated that the practice of hospital isolation rested on a sound basis of statistical proof. A good illustration of the exaggerated ideas which prevailed only a few years ago as to the results accomplished by hospital isolation is furnished in the Final Report of the Royal Commission on Vaccination. On page 45 the Commissioners say, referring to the decline in scarlet fever mortality, "We think that the steps which have been taken in various ways to isolate persons suffering from scarlet fever have largely contributed to this decline"; whilst in the Minority Report, the dissentient Commissioners go even further, saying, in reference to scarlet fever and some other diseases: "The recent development of proper hospital isolation has been most strikingly effectual in reducing, almost to insignificance, the mortality from these diseases." Such unreserved statements are all the more remarkable in that their

(a) They were clearly pointed out by Dr. J. T. Wilson in 1897, but did not at first receive the attention which their importance merited.

principal expert witness on this subject, the late Sir Thorne Thorne—than whom no one was better qualified to speak—had in his evidence emphatically dissociated himself from these optimistic views, saying: "I know that some people attribute it (the decline in scarlet fever mortality) to hospital influence; but wherever we have been able in a given large town to inquire how far any diminution has been due to isolation, we cannot make out that the diminution has in any sensible way been due to that practice."

It must be clear, from what has been stated above, that a diminution in the mortality of the disease cannot any longer be regarded as evidence of the value of fever hospitals, and the fact that such a serious fallacy was able to exist for many years is certainly rather disquieting.

Turning now to those large towns in which compulsory notification was in force for a considerable period—say ten years or thereabouts—before hospital isolation was begun, or at least before it was practised to any extent, we find *no evidence as regards the prevalence of the disease that any appreciable diminution has occurred.*

Derby, Nottingham, Bolton and Halifax are, I believe, the only towns in this class (among the larger towns), and in none of them can it be said that scarlet fever has shown any real tendency to decrease since the practice of hospital isolation was inaugurated. Among the smaller towns the experience is similar; if there are any exceptions they have not been published. Of course, if too short a period be taken for comparison the result might easily be misleading, for scarlet fever is a disease which naturally tends to fluctuate. Indeed, this tendency to fluctuate is one of the reasons why comparisons made with previous years in individual towns can scarcely be conclusive, especially as the number of towns in which a satisfactory comparison can be made at all is so small.

We must turn, therefore, if we really wish to settle this question, to the second of the two methods referred to—*viz.*, to institute comparisons between different towns—between those which do not isolate at all, or only to a small extent, and those which have practised the measure largely. Now, it is obvious that if the practice of hospital isolation has any marked effect in reducing either the prevalence of or mortality from scarlet fever we should expect those towns which have practised the measure much to suffer less from the disease than those which have neglected it. It would, however, be quite fallacious to pick out for comparison one single town which isolated much and another which isolated little. There might be local conditions in the one town, quite apart from the question of hospital isolation, which would account for a higher scarlet fever prevalence.

It would also be unsafe to take too short a period for comparison, as the presence or absence of epidemics might swamp any effect due to hospital isolation. But both these objections can be got over very largely, if not entirely, by taking a number of towns or districts and grouping them so as to get an average result, each group being made as large as possible, and the period covered as long as possible—at least ten years. To make the comparison still fairer, the larger towns may be considered separately from the smaller, and urban districts from rural. There is an important consideration, however, which certainly ought to

make any such comparison tell in favour of the isolating groups, for we may safely conclude that those towns or districts which have made the most serious and determined efforts to stamp out scarlet fever by "pushing" hospital isolation have also, with very few exceptions, been active as regards other preventive measures as well. Moreover, the mere fact that a sanitary authority picks out one disease for hospital treatment is certainly calculated to raise the importance of that disease in the eyes of the public, and so to make them more careful than they would otherwise be. This is certainly one of the indirect advantages of hospital isolation. On the other hand, those towns which have neglected hospital isolation have also, in many cases, been very backward and indifferent about disease prevention in general.

In spite of this consideration it will be found, if large enough groups be taken—the one isolating, and the other not—that the average attack-rate and mortality over a period, say, of ten years will come out almost exactly the same in each group.

The advocates of hospital isolation object to any comparison being made on the lines we have recommended. Comparisons are proverbially odious—to those who suffer by the comparison—but it is difficult to believe that much objection would have been taken if the isolating towns had shown a marked superiority.

#### THE "CONTROL" EXPERIMENT.

The importance of the "control" experiment is well known to every student of modern science. Without it, it is impossible to determine whether a given result is due to the supposed cause or not; and there are numberless instances where the employment of a "control" has revealed the most unexpected fallacies. In the case of the problem before us, a "control" experiment is furnished by those towns which have refused to follow the prevailing fashion and have not provided fever hospitals, or, where a hospital does exist, have only used it to a very small extent. If we find that in these towns—the bad isolators—the prevalence of or mortality from scarlet fever is, speaking generally, no greater than in the towns which we may regard as good isolators, the obvious conclusion which most unbiassed people must come to is that hospital isolation is accomplishing very little. We are justified in saying that if a non-isolating town builds a fever hospital and enters upon an isolating career it must not expect to see any appreciable diminution in the disease, even in ten or fifteen years' time; and the same applies to towns which enlarge existing hospitals and increase the percentage of cases isolated.

On the other hand, we have good grounds for assuming that if an isolating town were to abandon isolation, partially or even entirely, and utilise its fever hospitals for other purposes, nothing very dreadful with regard to scarlet fever would happen. As a matter of fact, necessity, which has so often been the mother of invention, has already provided several striking examples of this—notably at Oldham, in 1893, in Leicester, in 1892, and again more recently in 1903, and in Derby, in 1903. In these cases, owing to epidemics of small-pox, the fever hospital had to be reserved for that disease, and scarlet fever had to be treated at home—with very satisfactory results!

In this brief article no attempt has been made to give detailed statistics. In the space at our

disposal only selected figures could have been given, and selected figures, which must necessarily be one-sided, are open to objection. The question is too vast and too important to be settled off-hand, but needs to be made the subject of an organised inquiry by an impartial and authoritative tribunal. In the meantime, sufficient has been said to show that there are good grounds for dissatisfaction with the results which are being obtained in return for the great expenditure of public money which the hospital isolation of scarlet fever entails. These results, we may safely say, are very small indeed compared with the sanguine expectations which were raised when the measure was first introduced.

### THE ORGANISATION OF THE BACTERIOLOGICAL SECTION OF THE KING INSTITUTE, MADRAS.

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AN important circular letter has recently been distributed throughout the Madras Presidency by Lieut.-Colonel W. G. King, C.I.E., I.M.S., Sanitary Commissioner for Madras. It calls attention to the fact that Government has gone to the expense of supplying public facilities for securing bacteriological diagnosis. The laboratory throws open its doors to no less than six qualified medical men who may wish to carry out independent investigations. The bacteriological section is amply provided with requisite apparatus, which will be at the disposal of private as well as of official workers. Lieut.-Colonel King has appended to his letter the following article of mine as explaining the general scheme of the Institute. The departure is likely to interest public health workers at home in the United Kingdom, as well as in tropical countries.

#### I.—PUBLIC HEALTH.

The importance of bacteriological study in relation to sanitation needs no comment. In the large laboratories of Europe, and, indeed, throughout the world, the most diverse investigations in this relation are in progress, and questions regarding the bacteriology of water, milk, sewage and food are constantly being determined. Even agricultural methods and trade processes are becoming more and more based on bacteriological data. In India and the tropics generally, where the bacteriological fauna is very imperfectly known, there lies open an enormous field for research. Properly equipped laboratories are necessary for such work, and a large central laboratory in active working order has an importance scarcely to be over-rated. Such an institution should be the means not only of encouraging, stimulating, and assisting men occupied in private research, but, especially by reporting upon material sent in for examination, should be of use to all engaged in clinical, sanitary, veterinary or medico-legal work.

It will be obvious that the full extent and scope of the work of such a laboratory can only be roughly indicated.

In regard to matters more directly relating to public health we may instance the following as probably embracing the more ordinary investigations likely to be carried on:—

*The Bacteriological Examination of Water.*—The satisfactory condition of a water supply, the efficiency of a filtering system, and such like points can, as a rule, be roughly determined by the local sanitary officer, who can be readily supplied by the Institute with agar tubes and sterile Petri dishes. It will, however, in most cases be unlikely that this officer will have the means of undertaking more than an enumeration of colonies. When, from the number or appearance of

these, suspicion arises as to the presence of contamination, and a further qualitative examination is called for, it can be carried out from samples forwarded to the Institute.

In order that reports on such samples may be of value, it is essential that they should be collected and bottled with the greatest care. The use of an unsterilised bottle may quite prevent any idea being arrived at as to the bacteriological condition of the water when collected. For most purposes, an ordinary small stoppered bottle of a few ounces capacity may be used. It should be immersed in water and boiled for thirty minutes in a covered vessel, which should be kept closed until cool. As soon as the water is cool, the bottle should be emptied and at once closed with the stopper. In collecting samples with the object of testing a water-supply, all the usual precautions should be adopted. In cases where it is suspected that the water contains the cholera vibrio, it is well to include some water from the actual surface instead of, as in most cases, plunging the bottle to some depth before allowing water to enter.

The bottle when filled with water should be at once closed and the stopper firmly tied down. Samples should be forwarded with the utmost despatch. Where possible, the bottle should be surrounded in ice. When this is not obtainable, sawdust packing will serve as a fairly efficient non-conductor of heat. When sawdust is used, the bottle should be carefully wrapped in paper.

*The Bacteriological Examination of Milk.*—Milk suspected of containing tubercle bacilli should be forwarded in a sterilised (boiled) bottle. If possible, the sample should be packed in ice.

Milk suspected of being profoundly contaminated can always be examined bacteriologically and the number of organisms compared with that in ordinary specimens. It is essential in this case that the milk should be forwarded at once and packed in ice.

*The Bacteriological Examination of Sewage.*—Sewage effluents should be sent under similar conditions to those already noted for samples of water. For important investigations on matters relating to sewage the Institute possess a septic tank, filtering beds, &c.

*The Bacteriological Examination of Food.*—Food suspected of causing ptomaine poisoning should be forwarded for examination. Full reasons should always be given for considering the food to be the cause of the outbreak.

*The Action of Disinfectants.*—At a time when disinfectants of all kinds are being advertised, it is important that their efficacy should be proved before they are used. Samples of disinfectants sent to the Institute will be tested as regards their action on micro-organisms. A report explaining their good and bad qualities will be sent at the expiration of the experiments.

*Soil.*—Soil suspected of containing tetanus or anthrax should be forwarded in a jar or wide-mouthed bottle.

*Plague.*—No disease in India is of greater importance to the sanitarian than plague. In no other instance does so much depend upon the detection of the first case in any town or village. In many cases officers, not very conversant with the disease, have to decide whether or not such a case is cholera, and on this opinion may hang enormous potentialities. It is then not a small matter that in every suspicious case of sickness or death a direct answer, as a result of microscopical examination, can be given. The examination of blood is not of much use except in the final stages of fatal cases, but smears from the puncture of swollen glands in the bubonic cases and from sputum in the pneumonic will enable a diagnosis to be at once arrived at. In the case of bodies found dead and suspected of being cases of plague, it is well to send smears of the spleen pulp, as in every form of the disease this organ contains the bacilli.

To enable films for the above purposes to be sent on the least suspicion, slides have been supplied to all medical officers in the Presidency of Madras.

The most satisfactory way of making films of gland

fluid or sputum is by the use of a needle as described later in this paper. When spleen pulp is in question, the edge of another slide will be found most useful. In all cases the slide should be wrapped in clean paper and securely packed.

When plague is suspected in rats, a recently dead animal should be opened and smears made of the spleen, liver and of any inflammatory condition noted.

## II.—CLINICAL DIAGNOSIS.

Routine bacteriological and pathological examinations of clinical material are undertaken at home in several institutions, notably the Pathological Diagnosis Society of London, and a similar one at Liverpool. At the Pasteur Institute at Kasauli also such specimens are received and reported upon. The bulk of material sent to these institutions consists of sputum from suspected cases of phthisis, of blood for the determination of the Widal reaction, and swabs from diphtheritic throats. At the same time, urinary deposits, tumours and many other miscellaneous materials are submitted for report. In starting a similar institution in Madras, we recognise that there is a far wider and more varied field for such work than at home. Malaria, filaria, and other parasitic diseases are enormously prevalent. Tropical medicine indeed largely deals with parasites. Its tendency is to show definite causes for disease in parasites of different nature, both bacterial and protozoal, and to care less for the secondary clinical manifestations. On this account, microscopical and bacteriological methods of diagnosis are becoming necessary. Many diseases indeed are unrecognisable apart from microscopical examination, and the diagnosis of many others must always be uncertain without it. In their differentiation the microscope will play a large part. We may instance in this respect the startling discovery by Donovan of a new disease equal in importance to tubercle or cancer. Spirillum fever can scarcely, as appears at present, be confined to Bombay. It is not by any means certain that human trypanosomiasis is confined to Africa. Such points and the differentiation of entirely new diseases are almost certain to follow upon widespread examination of the blood and tissues of obscure cases. The Institute ought, then, to be of use in the diagnosis of obscure and difficult cases, in still further clinching the diagnosis of malaria and typhoid, and in leading possibly to the discovery of entirely new causes of disease. The field for useful work on these lines is very great, but we may indicate roughly the more usual examinations which it is proposed to make and to report upon.

1. *The Examination of Material for Tubercle, the Gonococcus, the Pneumococcus, the Leprosy Bacillus, the Micrococcus Melitensis, the Vibrio of Cholera, and other well-known micro-organisms.* In this respect the presence of human anthrax should be borne in mind, also that scrapings from ulcers of all kinds are likely to yield in many cases evidence of an unsuspected condition—i.e., leprosy, infection with Donovan bodies, &c.

2. *The Examination of Blood for Specific Serum Reactions.*—For useful purposes these are practically confined to reactions with the typhoid bacillus and the *M. melitensis*. Capillary tubes, &c., can be obtained gratis from the Institute.

3. *The Examination of Films of Blood and Smears from Different Organs.*—It is expected that the greatest help will accrue from the result of blood examinations. By the examination of peripheral and splenic blood it will be possible to determine the presence of the malaria parasite, filaria, Donovan bodies, trypanosomiasis, spirilla, the plague bacillus, the Malta fever organism and others. In smears from ulcers and abscesses, fæces, &c., the amoeba coli, balantidium, ova of worms, &c., will be notified. By a blood examination also the condition of leucocythæmia, eosinophilia, and other changes will be made apparent.

4. *The Examination of Tumours and Diseased Tissues.*—In this respect there is an unlimited field for research. In practice in the tropics, conditions are constantly being encountered unlike anything seen at home. As a rule, these are dismissed after a rough diagnosis has placed them in some general group. By forward-

ing properly-preserved specimens, a great deal more might be learned regarding their real nature.

In transmitting tumours or pieces of tissue for examination only small pieces, never larger than a bean, should be placed in absolute alcohol for two hours and then transferred to 70 per cent. alcohol. In case absolute alcohol is not at hand, the pieces of tissue should be placed in rectified spirit. Specimens should be transmitted in weak alcohol, 70 per cent. In some cases it may be advisable to send the whole tumour. It should be forwarded in rectified spirit, freshly added before despatch, or in formalin 5 per cent.

5. *The Examination of Urinary Deposits, Fæces, Vomit, &c.*—All specimens of this kind should be sent with a crystal or two of thymol to prevent further changes. For the amoeba coli films should be made of the fæces immediately they are passed. Urine suspected of containing hæmoglobin can be sent for spectroscopic examination.

6. *The Identification of Mosquitoes, Especially of Anopheles.*—All biting flies are of extreme interest and they should be forwarded for identification. Even if the specific name cannot be at once given the genus in most cases can be notified to inquirers. All blood-sucking animals—ticks, fleas, lice—are of great interest, and if they are not identified by the Institute, steps will be taken to have all specimens forwarded to authorities at home.

Worms and specimens of fæces containing ova should be sent for identification. The possibility of new species of parasites should be constantly borne in mind.

*Tubercle.*—In the case of sputum, the morning expectoration should be made direct into a small, wide-mouthed bottle containing a little 1 in 20 carbolic and the bottle at once vigorously shaken. The bottle itself may be sent by post; or films may be made from the emulsion, and these only forwarded.

For tubercle bacilli in urine, the deposit should be mixed with a little 1 in 20 carbolic and forwarded without delay.

*Leprosy.*—Smears from open sores, or from scrapings of the leprosy lesions, will enable a diagnosis of leprosy to be at once confirmed. Pieces of tissue removed *post-mortem* should be sent for report. The splenic condition is interesting and smears from this and other viscera will be valued.

*Infective Granulomata.*—Smears from ulcers suspected of being due to yaws, syphilis, and possibly other undescribed causes should be sent for examination. Even if no result is obtained in many cases, there are sure to be instances where the diagnosis may have to be revised.

*The Gonococcus.*—Suspected discharge should be spread in as thin a film as possible upon a clean slide, by means of a needle as in making a blood film. Several slides should always be sent, as it is necessary to stain in several ways for diagnosis of the organism. Discharge from ophthalmia suspected of being due to the gonococcus may be similarly treated.

*The Pneumococcus.*—Films of sputum or smears from the lungs, meninges, &c., will, in cases of pneumococcus infection, often enable a certain diagnosis to be arrived at.

*Plague.*—The glands in plague, when swollen, contain the bacillus in large numbers. A little fluid should be drawn off by means of a hypodermic needle and a few smears made as described above.

In the pneumonic form sputa should be forwarded (film). Attention is also directed to the possibility of bacilli being present in the saliva in cases of submental glandular enlargement. In fatal cases films from the viscera and glands should be made. Splenic puncture in doubtful cases promises to be of great diagnostic value.

*Anthrax.*—In cases of suspected malignant pustule, a little fluid should be drawn by means of a hypodermic syringe from the tissues just beyond the slough. A smear should be made of this and the remainder placed in a sterile capillary tube for instant despatch. The tube should be carefully sealed.

The occurrence of pneumonic and intestinal anthrax should be borne in mind. Such cases, as well as cases simulating acute specific fevers or plague, may be readily overlooked.

*Diphtheria.*—Smears of the throat mucus should be forwarded. But for any definite answer to be given, a swab must be forwarded. Sterilised swabs in tubes for this and other similar purposes can be obtained from the Institute.

*Cholera.*—Films of some mucoid flakes should be forwarded. A carefully sealed capillary tube of the fæces should also be despatched at once.

*Dysentery.*—Films of dysenteric motions made immediately the motion is passed will, in cases of amœbic dysentery, show the amœba coli. Non-amœbic dysentery is to be suspected when such an examination is negative. A capillary tube of fæcal matter may be sent for the possible isolation of virulent organisms.

*Typhoid.*—Serum reaction as a diagnostic test for typhoid has met with a good deal of criticism. This has been largely due to a want of confidence between the bacteriologist and the clinician. In deciding upon the result of a serum test, several very important facts must be considered. Since a reaction is practically never obtained prior to the fourth or fifth day, and often not until the seventh, allowance must be made for negative results in the early stages of undoubted typhoid. Towards the third week the reaction becomes very intense, and, unless at this time the test acts in considerable dilution, grave doubt should be entertained as to its specific nature. In some cases it is difficult to say whether the reaction is of sufficient degree to raise it certainly above the possibility of normal serum action. If such a reaction occurred on the sixth day, it would be very suspicious of typhoid infection and a later development of a more intense reaction. If the same degree of reaction took place in the third week, it would mean little. In reporting upon blood sent for the purpose of the Widal test it will be necessary to fix a limit of dilution, which at the same time will detect the early onset of agglutinative action and will be removed from all possibility of normal serum action. This is pretty generally recognised to be a 1 in 30 dilution with most laboratory cultures of the typhoid bacillus. Specimens of blood for the Widal reaction should be taken in small pipettes which may be obtained from the Institute.

In cases of cystitis or abscesses suspected to be due to the *B. typhosus*, a capillary tube full of the fluid should be sent for bacteriological examination.

*Malta Fever.*—Undoubtedly the best way to detect Malta fever is to grow cultures from blood obtained from the spleen. Microscopical examination of such blood would in default of this be of value. As a matter of fact, no attempt has been made to do either of these in cases reported from India. Such cases have been diagnosed on the serum reaction. Unfortunately what we have said regarding typhoid serum reaction is still more the case when we come to deal with the *M. melitensis*. Owing to the fact that attenuation has in most cultures of *M. melitensis* greatly increased their susceptibility to normal serum action, the limit of specific reaction has to be raised to 1 in 100 or more. The neglect of this precaution has probably led to some mistakes in the diagnosis of Malta fever, and to a suspicion of the value of the serum test in general. There is, however, no reason why with greater precautions the serum test for Malta fever should not be of value.

*Malaria.*—Perhaps no test is of greater value in tropical medicine than the blood examination in an obscure case for the malaria parasite. In sending specimens of blood for this purpose as good a film as possible should be made. It is generally advisable to send several.

The slides used should be rubbed perfectly clean, after dipping in water, with a soft cloth, and protected at once from dust. Before taking specimens of blood the prepared slides may be placed in a small pocket slide box or merely wrapped in a clean sheet of note

paper. A packet of half a dozen prepared slides wrapped in a sheet of note paper, which is afterwards transfixed with a surgical needle, is a most convenient form of carrying the necessaries for taking specimens at the bedside. The needle should be an ordinary triangular pointed surgical needle. The last phalanx of the finger is taken between the finger and thumb of the left hand of the operator and gently pressed to force the blood towards the pulp of the finger. A slight prick with the needle causes a drop of blood to exude. When the drop reaches the size of the head of a pin, a slide is held in the right hand and lowered on to the drop. Care should be taken not to 'dab' the slide on the skin. If the drop is too large, wipe it away and squeeze a fresh one. The drop should be transferred to the slide about one-third of an inch from the end. The slide is then changed to the left hand, the finger and thumb grasping the end nearest to the drop. The right hand again takes the needle and holding it by the pointed end, lays the cylindrical shaft transversely to the slide and across the drop of blood. After waiting about a second—*i.e.*, until the blood spreads to the extent of one-third inch between the slide and the needle, the needle is evenly and not too quickly carried to the right and so along the whole length of the slide. The right amount of pressure is very easily learnt, and the making of a useful and good film is far easier in this way than in any other way known to us. Immediately the film is made it should be waved to and fro until dry in the air.

The slide when made should be carefully preserved from dust and wrapped at once in clean note paper. Notes can be written in ink on the back of the slide or by writing on the film itself with a needle.

To obtain blood from the spleen use an ordinary hypodermic needle. A large needle is unnecessary and liable to be followed by hæmorrhage. Splenic puncture should be done in all cases showing enlargement of the organ and a puncture of this organ would not be amiss in any obscure case of disease accompanied by rises of temperature. The following points should be observed in films sent for the detection of malaria: (1) it is not necessary to take the blood only when the temperature is high; (2) in sending films for a leucocyte count it is best to take the blood in an apyretic interval as, at this time, the increase in the large mononuclear leucocytes is greatest; (3) films should be thinly spread and should be forwarded at once without fixing.

*Filaria.*—Blood should be taken in the evening. The films should be made a good deal thicker than when detection of the malarial parasite is desired.

*Trypanosomes.*—Films as for malaria should be made. It is well to remember that trypanosomes are often found in œdema fluid when they are very scanty in the blood.

*Donovan Bodies.*—For forms in the spleen make films as in the case of malaria. To determine the presence of the bodies in ulcers snip off small pieces of granulation tissue with a sharp scissors and, after crushing, make a film, using the edge of a glass slide to spread the material.

*Relapsing Fever.*—Blood films should be taken at intervals, when the presence of the spirillum is suspected, as it at times disappears from the blood.

Examination of the peripheral blood for plague and other acute infective diseases is not of much use except possibly in the last stages. The examination of splenic blood is, however, of the greatest possible value not only in such diseases but in the study of infective diseases generally.

*Mosquitoes and Flies.*—These should be captured in tubes, specimen or test tubes, and killed with tobacco smoke. When dead they should, with as great care as possible, be turned out on to a clean sheet of paper. They should never be touched with fingers or forceps. They should be placed upon their dorsal surface and transfixed with a fine entomological pin No. 20, which has first been pushed through a piece of thin Bristol board. The specimen whenever possible should be mounted; if no fine pins are at hand it is better to place



the insects in a piece of glass tubing or between two sheets of tissue paper in a box.

Fleas, ticks, lice are best forwarded in spirit. All soft parasites should be given a plentiful supply of rectified spirit and labelled by placing a piece of paper in the tube with pencil writing upon it.

[ED. NOTE.—The third part of this interesting paper deals with veterinary diagnosis, and has been omitted here as it deals mainly with matters of interest to tropical readers.]

## The Out-Patient Departments.

### TOTTENHAM HOSPITAL.

*Dermatological Cases under the Care of G. NORMAN MEACHEN, M.D., M.R.C.P.*

CASE I.—*Accidental Vaccinia*.—A little boy, *æt.* 6, was brought by his mother with a "sore place" on his forehead, which had been there about six days. There was no history whatever of injury, but the mother stated that the child's baby brother of a few months old had been vaccinated a fortnight ago, and that they had been playing about together. On inspection, there was seen on the left temple a typical vaccinia pustule with a central scabby portion, and much local congestion in its immediate vicinity. The eyelids were swollen and oedematous, and the pre-auricular lymphatic gland was enlarged upon the same side. No other lesions were present. The boy had been vaccinated when an infant. From the clinical aspect alone, there should have been no difficulty in recognising the nature of this case, apart from any history that would lead one to suspect accidental vaccinia. This lesion was said to have begun as a "small pimple" which, in all probability, was really inoculated upon the site of an unnoticed abrasion of the skin upon the temple. The clearly defined circular shape of the pustule with the accompanying inflammatory reaction and the central part beginning to dry up would suffice to distinguish it from an impetigo or a furuncle. Enlargement of neighbouring lymphatic glands almost always occurs. The hands are, naturally the parts of the body more usually subject to accidental contamination with the vaccine virus, but typical lesions have been observed upon the female genitals, and upon the nasal mucous membrane. The interest of the present case lay in the fact that previous vaccination upon the usual site six years ago did not appear to have diminished the patient's susceptibility to a fresh inoculation. A simple lotion of boracic acid was ordered for external application.

CASE II.—*Bromidrosis of the Feet Associated with Eczema*.—The patient was a boy, *æt.* 14, an assistant in a public library, and, therefore, upon his feet the greater part of the day. His complaint was a painful soreness of the toes which rendered walking very difficult. He had been thus troubled for about three weeks. On examination, the skin of the toes of both feet was sodden, red, and weeping. The back of the heels were eczematous, and the soles were affected to a less extent with papules and minute pustules. The discharge had soaked through into his socks, and altogether he was in a pitiable plight. The left foot was much worse than the right. He stated that when he was well his feet always sweated a good deal. The hands were affected with a drier, squamous eczema. Otherwise he was in good health. There was also slight acne of the forehead. The boy said that he could not stay away from his work, so that the treatment was not quite so satisfactory as if he had rested the feet in the horizontal position. However, he was given a weak tar lotion for bathing the affected parts with, followed by dusting the toes well with an antiseptic, astringent powder composed of five grains of tartaric acid, ten of boric acid and equal parts of starch and zinc oxide to the ounce. An ointment of zinc and boric acid was also ordered for application to those parts which were more sore than the rest. Strict cleanliness as regards

foot-gear was enjoined at the same time. When seen a week afterwards the local conditions had much improved.

CASE III.—*Dermaographia of a Severe Type*.—The patient was a girl, *æt.* 18. She complained of intense irritation of the skin, which appeared to "come up in a rash" whenever she became heated. The affection had been present ever since she was a small child, and now the slightest friction with the clothes or rubbing of any kind would produce a wheal. She had had no previous illnesses. On examination, the skin appeared to be normal with the exception that there were several erythematous areas where the clothing had pressed. On passing a blunt-pointed pencil or the finger-tip lightly over the skin of the back, a vivid wheal was produced after an interval of ten to twenty seconds, which was speedily surrounded by a red halo. The sensation experienced was one of heat or slight burning. She was pale, but the cardio-vascular system was normal. The bowels were somewhat constipated.

Dr. Meachen remarked that urticaria factitia was one of the commonest manifestations of the so-called neuroses of the skin. This group of cutaneous disorders had been specially observed by Van Harlingen, Savill, and others, and the generally accepted view was that the vaso-motor system was at fault. Many varieties of erythema, morbid blushing, and the condition known as dermatographia, of which this patient was such a good example, were included under this category.

Acting upon the supposition that the intra-cutaneous capillaries were impaired in tone, five grains of the supra-renal extract were prescribed three times a day. Careful regulation of the bowels was also strictly enjoined. A simple anti-pruritic lotion of calamine was ordered for local application.

## British Health Resorts.

### VIII.—ST. IVES (CORNWALL).

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

THE quaint little fishing town of St. Ives has long been beloved by artist and antiquary. Situated on the northern coast of the Cornish peninsula, it occupies a peculiarly picturesque position on an isthmus which separates a small promontory from the mainland, and looks eastward across the beautiful bay of St. Ives. The ancient town, with its narrow and roughly paved streets, solid, grey, irregularly placed houses, has much the aspect of an old-world Breton or Flemish town. St. Ives is a port and fishing centre of great antiquity. Even still, in spite of the modern builder's efforts and the tourist's invasion, old custom and long-established tradition rule and regulate the toil and delights of the simple, strong, peace-loving fishermen and hard-working and patient watching wives of the harvestmen of the sea.

St. Ives deserves to take high rank among our Western health resorts. It seems suited to the needs of many classes of visitors needing quiet, shelter, and yet pleasing occupation for the mind. We have stayed at St. Ives in the springtime and consider it a peculiarly suitable resort for this period of the year. Its position also ensures conditions which make it a pleasing summer station. And in the winter it can offer much that is particularly welcome to the invalid, for the climate is warm, equable and considerable sunshine is enjoyed.

Dr. J. M. Nicholls, the Medical Officer of Health, has kindly furnished us with copies of his reports for recent years. In 1901, the population of the St. Ives Urban Sanitary District, having an area of 1,100 acres, was 6,697, a density of population per acre of 6.69. The birth-rate in 1903 was 26.13 and the death-rate 14.18. The cancer mortality is returned at .59 per 1,000 of population and that from phthisis as .74 per 1,000. The water supply has been improved and progress is being made in sanitary reform. The mean temperature according to the report for 1903 was 52.22°, the highest

maximum being 71.3°, in July, and the lowest 29.5°, in January. The rainfall was 39.51 inches. The number of rainy days is returned as 209 and sunshiny days as 209.

The invalid visitor will not lack comfort and may even secure luxury in St. Ives.

The Tregenna Castle Hotel, admirably conducted by the Great Western Railway Company, is quite un-hotel like in appearance and well provides the comforts of a country mansion after a manner peculiarly welcome to the visitor seeking mental rest and bodily relaxation. From personal experience we can highly recommend this charmingly situated residence. St. Ives is not rich in hotels, but apartments can be found well suited to the requirements of the invalid. The immediate neighbourhood of St. Ives offers numerous advantages. Sandy bays of Porthminster and Carbis provide safe playgrounds for children. The golf links at Lelant have justly gained much distinction and attract enthusiasts from all parts of the country. The bay is ever at hand for boating and bathing; and the near highland supplies bracing opportunities for the pedestrian.

We consider St. Ives a particularly suitable resort for the artistic invalid needing a warm, light, sheltered and yet peaceful resort. It undoubtedly meets the requirements of many overworked professional men and is well suited to the special needs of sufferers from respiratory weakness. Convalescents from acute diseases and those recovering from prostrating affections may be expected to do well at St. Ives. Through the enterprise of the Great Western Railway, St. Ives, although 324 miles from Paddington, can be reached in a little over 7 hours; a through carriage can be taken to St. Erth Station on the main line, which is only 4½ miles distant from St. Ives.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, August 28th, 1904.

### TREATMENT OF COMA.

COMA is a state of somnolence characterised by the more or less complete loss of intelligence, sensibility, and mobility.

Apoplexy is not synonymous with coma; it precedes it, and is constituted by ictus or sudden loss of the cerebral functions. After a very short period, when this condition persists, coma follows. The treatment of coma varies with the affections which gave rise to it, says M. Fiessinger. It is met with in—

- (a) Affections of the brain and its membranes.
- (b) In certain nervous affections.
- (c) In certain intoxications.
- (d) In infectious maladies.

### DISEASES OF THE BRAIN AND ITS MEMBRANES.

*Traumatic lesions* of the cranium produce coma from compression by an osseous fragment or from hæmorrhage. Surgical treatment in such cases is clearly indicated. If the case is one of cerebral tumour, the patient will be placed on the specific treatment in the hope that the neoplasm may be of syphilitic nature. In case of failure surgical treatment, consisting in trephining and the extirpation of the tumour, especially if a limited paralysis indicates the exact place of the operation, will be adopted. Before, however, having recourse to this operation, lumbar puncture might be tried, which is an excellent palliative for vomiting and headache; it can also act on the coma when it is due to an excess of cerebral tension, as might occur in cases of tumour. Care should be taken not to remove more than two or three drachms of the liquid. The evacuation may be renewed every two days.

*Coma with contractions* in a child or in an habitual drinker indicates hæmorrhage of the membranes. The treatment is that of ordinary encephalic affections:

local or general blood letting, ice to head, calomel, mustard to the extremities. Almost the same treatment is used for *cerebral hæmorrhage* and softening of the brain. The coma in these two affections is difficult to differentiate one from the other.

*Embolus* produces rapid coma without vertigo or premonitory symptoms. The co-existence of a cardiac or aortic lesion will clear up the diagnosis. Diffusible stimulants, injections of ether, camphorated oil dry frictions, sinapisms, should comprise the treatment.

*Thrombosis of the sinus*, sometimes preceded by hemiplegia, monoplegia, Jacksonian epilepsy, may provoke rapid and complete coma. Thrombosis may be suspected in a patient cachectic from dysentery, cancer, chlorosis, tuberculosis, or who has suffered from otorrhœa. Here treatment is powerless.

Sometimes *acute mania* terminates by delirium followed by coma. As it is a case of encephalitis with congestion, lumbar puncture may be tried. Abscess of the brain frequently follows tuberculous osteitis of the petrous portion and is usually terminated by coma. It is for the practitioner to judge if the patient can support an operation. The coma of *general paralysis* succeeds to apoplectiform seizures. It is generally of short duration. The mercurial treatment appears to give some good results. For a long time M. Huchard places a seton at the back of the neck as a prophylactic treatment of the complications of general paralysis as well as in the majority of comatose accidents in other cerebral affections. The seton is left in place from three to six months; it is not very cleanly, but efficacious.

*Insolation* is accompanied by coma. Application of ice to the head, blood letting (12 ounces) and a drastic purgative is the treatment habitually employed.

### NERVOUS AFFECTIONS.

*Epilepsy* is a frequent cause of coma. It forms a part of the attack and follows the convulsive stage. Active treatment is not necessary: the epilepsy should be treated and not the coma, which is rather favourable to the patient by furnishing to the organism the means to recuperate the energy spent on the paroxysm.

*Hysteria* is accompanied by sleep rather than coma. The limbs are slightly contracted, maintaining sometimes the cataleptic attitude given to them. Children are sometimes seized with coma from a reflex cause. Worms may be suspected in such cases and treated accordingly.

*Intoxications*.—Besides the coma produced by such poisons as opium, belladonna, carbonic oxide, and alcohol, there exist others produced by certain maladies—as diabetes, uræmia, dyspepsia, and cancer. The *coma of diabetes* is observed in the gravest forms of the malady. Sometimes, and especially in children, coma is the first sign of diabetes. A good deal has been written on this complication. The alkaline treatment—one to three ounces of bicarbonate of soda in the 24 hours—has been recommended, but without much result. Preventive treatment is the surest—absolute suppression of meat, large doses of bicarbonate of soda, drastic purgatives. The treatment of *uræmic* coma is that of coma from œdema of the brain, as observed in Bright's disease.

### INFECTIOUS DISEASES.

Two kinds of coma are observed in infectious maladies—*coma vigil* (typhoid fever) and *profound coma* with immobility and complete insensibility of the patient (eruptive fevers, paludism, acute articular rheumatism). The treatment varies with the nature of the causal affection, but generally speaking, warm baths (pneumonia, cholera), cold baths (typhoid fever), subcutaneous injections of caffeine, ether or camphorated

oil prove sufficient. At the same time the patient will absorb cooling drinks in abundance, and if he is strong enough to bear it, from six to eight ounces of blood may be taken from the arm.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 27th, 1904.

At the meeting in Prague, Lielebaen reported on a few cases of œsophagotomy, which he had performed on patients for obstruction in the œsophagus, that were quite out of proportion to the size of the foreign bodies impacted.

The first was a child, æt. 1½, who had swallowed a button 23 millimetres in diameter. It was observed by the œsophagoscope, but all ordinary efforts failed to lift it. Surgical bleeding commenced that led to immediate operation. When the gullet was opened, the wall of the tube was found quite gangrenous and thin, which led to a fatal termination within twelve hours after the operation, owing to an acute attack of lobular pneumonia.

The second was a child, æt. 5, who swallowed a piece of pipe stem 25 millimetres in diameter. Every effort to remove it by probing, &c., failed, although it was only 14 centimetres beyond the back teeth. The speaker saw the case a week after the accident, but he failed to remove the obstruction, although discernible with the œsophagoscope. He operated and left the opening without a stitch for twelve days, through which he passed a tube. The wound finally healed, and the patient recovered.

He related a third—a servant, æt. 17, who swallowed a small bone while eating duck. She was unable to swallow fluids, had great pain, and right-sided torticollis. The operation revealed part of a duck's cervical vertebra impacted in the wall. The patient rapidly recovered.

#### KERATOCONUS.

Bosser exhibited a female, æt. 21, who had suffered from the malady for two and a half years. The treatment consisted in cauterising the membrana Descemeti till perforation was produced, which was accomplished after the third application. Before the operation she was only able to discern fingers one metre distant, now she was able to do so at ½.

He also showed an interesting condyloma scleræ, which might easily be mistaken for a gumma. The man was æt. 25, but had no sign of secondaries such as papules in mouth, &c.

#### HEMIANOPSIA IN URÆMIA.

Pick gave a long and exhaustive history of a case of hemianopsia coming under his care. The patient was a tripara in her ninth month of pregnancy, with all the symptoms of uræmia and eclampsia. Labour was prematurely induced, which improved the uræmic symptoms, but this was followed suddenly by amaurosis that prevented the patient distinguishing between light and darkness. After a time this improved and two weeks after she was so much better that she left the hospital, but after a short time at home she felt her right arm had grown quite weak, which induced her to seek medical advice.

On examination, she was found suffering from chronic nephritis, hypertrophic cardia, hemiparesis dextra, and distinct right-sided hemianopsia, with slight retinitis and albuminuria.

The paralysis soon improved but the hemianopsia continued. Pick recollected another similar case he attended in 1897 which died. The post-mortem revealed

a soft circumscribed centre in the second occipital convolution, which presumably had its origin in an embolus. In many cases, however, of uræmia the amaurosis is observed to be very transitory, passing off in one or two days and not exceeding a week. He considered the case he had shown was one of a toxic origin which had produced the cerebral lesion.

In the discussion that followed, Luksch and others considered the real cause of the amaurosis to be due to emboli rather than toxin, or a toxin lesion of the cerebral substance.

#### ANTHELMINTICS IN CHILDREN.

Ritter drew attention to the difficulties and dangers of using *Filix mas*, which he had used for the last four years in the Franz Josef's. He considers the *Floreo kusso* to be much better, although it was not a trustworthy drug in its results. In twenty-eight cases he had used the *Filix mas* and only succeeded in six cases to securing the scolex.

The "junq clause" preparation of *semina cucurbitæ* was a much more efficacious drug for tænia. This is an extract of the seed having a dark, thick consistence and an agreeable taste. One dose represents 300 seeds. In eleven cases he had only three failures to obtain the scolex. Its great advantage lay in its agreeable taste, efficacy, and freedom from any danger to the patient. After a very short interval the appetite is good, and it may be repeated without any danger.

The mode of prescribing it should be observed. The night before, a dose of opening medicine or an enema should be given to clear the bowel, after which a little soup or coffee should be given as supper. In the morning the "junq clause" may be given, followed in two hours by castor oil or other aperient.

### Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, August 27th, 1904.

#### HYPEREMESIS GRAVIDARUM.

DR. ODÓN (TUSZKAI, Professor of Gynæcology, Budapest, whose contribution on hyperemesis gravidarum appeared in these columns about a year ago, now concludes his investigations in the following summary:—

I.—Hyperemesis produced solely by gravidity is one of the rarest complications of pregnancy.

II.—We have strictly to distinguish between vomitus gravidarum occurring during gestation, and between hyperemesis gravidarum specifica. Also we have carefully to discern by exclusion those diseases which cause vomiting in pregnant women, too; thus: gastric troubles, meningitis, peritonitis, hydrops, &c.

III.—The diagnosis of hyperemesis gravidarum can be made with certainty under the following conditions: (a) If we were able certainly to exclude the diseases mentioned under II., *viz.*, with the adoption of all the diagnostic and therapeutic methods and means. (b) If after these we find all the characteristic clinical symptoms, *viz.*, great local tenderness of the peritoneum and of the uterus, which tenderness not only increases on bimanual examination, but also gives rise to vomitings or violent retching and nausea. (c) If the frequent and severe vomitings occur also without taking food, and show within a short period the symptoms of inanition.

1. The quick decrease of the body weight, the daily quantity of urine, its chlorides and the red blood corpuscles of the blood.

2. The increase of the quantity of urine, its specific gravity, also the alkalinity of the blood, and the pulse-rate.

3. The appearance of albumin and kidney elements in the urine, and the presence of normoblasts and uninuclear megaloblasts in the blood.

4. The sudden fall of the morning temperature, and in opposition to this, the febrile or subfebrile rise of the same.

IV.—The symptoms of hyperemesis gravidarum were explained from the irritation of the perimetrium, which most probably originates on account of its individual and occasional properties from a local atrophy, and thus it is in causal nexus with gravidity.

V.—Prognosis is evidenced from the degree of inanition, in relation to the bodily condition of the individual. Evidence is gained by the above-described biochemical reactions.

VI.—On these grounds we shall be in the position to employ causal treatment, which in the forefront is conservative (local cold, heat, complete rest, large doses of opium), and only in cases of entire failure do we interrupt pregnancy, when the life of the mother is endangered. This operation can be performed very easily and comfortably by the method described above.

## The Operating Theatres.

### ROYAL FREE HOSPITAL.

GASTROSTOMY.—Mr. T. P. LEGG operated on a man, *æt.* 46, who had suffered from difficulty in swallowing solid food for nine months, and during the last three months had been getting very much thinner. For the past week the patient had been unable to take either solid or liquid food. He had also had a good deal of pain in the mid-dorsal region. On admission he was considerably emaciated and at once regurgitated any liquid which he attempted to swallow. There were several enlarged firm glands in the supra-clavicular spaces on both sides of the neck. He had no cough. A full-sized œsophageal bougie could not be passed further than nine and a half inches. A small bougie (No. 12) passed seventeen and a half inches, but was tightly gripped about nine inches from the teeth. A No. 15 bougie was stopped nine and a half inches from the teeth. The diagnosis was obviously one of carcinoma of the œsophagus, and a modified Franck's method of gastrostomy was performed. A vertical incision two and a half inches long was made just to the left of the middle line; the rectus sheath was opened and the fibres of the muscle separated; the peritoneal cavity was opened in the same line and the stomach at once brought into view, and a cone-shaped portion brought out of the wound. To the apex of the cone a couple of silk sutures were fixed. A second incision one inch long and parallel to and an inch and a half to the left of the previous incision was then made; this incision opened the sheath of the rectus near the outer margin of the muscle, the fibres of which were split into an anterior and a posterior layer by passing a blunt dissector from the second to the first incision through the substance of the muscle. A pair of forceps was next passed through the gap in the muscle thus made, and the guide sutures, which had previously been fixed to the stomach, were seized and drawn through. The cone of the stomach wall was then made to occupy the space between the layers of the rectus muscle, the apex being drawn through as far as the second incision, to which it was fixed by four sutures passed through the serous and muscular coats of the stomach and the skin and rectus sheath. The base of the cone lay in the

first incision and was fixed to its right margin by three or four stitches which united the fibres of the rectus, the posterior layer of the sheath and the peritoneum to the sero-muscular layer of the stomach. The apex of the cone was incised and the mucous membrane fixed by a couple of sutures to the muscular coat. A No. 10 catheter was passed into the opening thus made and to prevent it slipping in or out, a silkworm-gut suture was passed through it and the skin a short distance away from the opening in the stomach. Four ounces of peptonised milk were passed through the catheter into the stomach before the patient was taken back to bed. Mr. Legg said there were two chief methods of doing gastrostomy, and the one adopted here was only possible when the stomach was sufficiently large to allow a cone-shaped piece to be easily drawn out of the wound; this was not always the case, and under these conditions an operation known as Witzel's had to be done. The operation of gastrostomy, as had just been performed, was, he thought, most satisfactory, for even on coughing there was practically no escape of the gastric juice and contents of the stomach, which had such an irritating effect on the skin, the cone of stomach being entirely surrounded by muscle fibres, which act as an efficient sphincter. Mr. Legg thought it best to open the stomach at once and to give the patient food at the completion of the operation; there was no risk of the contents of the stomach infecting the peritoneum, and the patient does not vomit as a rule. Another reason for opening the stomach at once, he pointed out, was that the patient not infrequently had been unable to take sufficient nourishment by mouth for some time previous to the operation. At best, he remarked, gastrostomy can only be considered as a palliative measure; the patient frequently puts on flesh, recovers some degree of strength, and is able to swallow naturally, at least for a time. Whether life is prolonged or not to any appreciable extent was, he considered, doubtful, but the rest of the patient's existence was rendered far more comfortable and bearable. The method of feeding of patients after the operation was, he considered, very important. His usual plan, he said, was to give four ounces of peptonised milk with half an ounce of brandy every four hours, increasing the quantity to six, eight and ten ounces from time to time and diminishing the amount of peptonisation. If he can swallow it was a great comfort to the patient to supplement the artificial feeding by natural means; one often finds that the patient is able to take bread and milk, milk pudding and mince-meat when previous to the operation he had been quite unable to swallow. The only objection, however, to this being allowed was the irritation of the growth in the œsophagus.

A week after the operation was performed the patient was getting up and after a fortnight was going out daily into the hospital square, feeling much stronger and putting on flesh, while no longer looking so emaciated.

### Medical Communism.

AN interesting medical innovation has just been made by the town of Zurich. It has created a medical tax of 3s. 7½d. per head of the population with a view to raising £20,000. Forty doctors in the town will share this money, each receiving an annual sum of £500. In return for this salary they will be expected to give their services to "all" the inhabitants of Zurich.—*Advertiser.*

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 31, 1904.

**MEDICAL MEN AND ADMINISTRATIVE JUSTICE.**

No section of the community comes habitually into closer contact with the inner life of the nation than the medical profession. Their duties carry practitioners of medicine into the homes of all classes as well as into workhouses, hospitals, schools, prisons, and reformatories. In this way they become acquainted with the histories of a vast number of persons, who, in many instances, confide their private affairs as a matter of course to the ear of their medical attendants. They are therefore in a position to know as much as most people how administrative justice deals with accused persons in all parts of the United Kingdom. As a rule, the average Briton who comes across a miscarriage of justice shrugs his shoulders and says nothing more about it. From a prolonged experience of police administration he knows that little satisfaction on the one hand and a vast amount of trouble and annoyance on the other are likely to result from any personal intervention of his own in any matter of individual injustice. In New York, where Tammany rules the roost, citizens live under a reign of police terror, in which blackmail, intimidation, organised conspiracy and legalised violence appear to be the recognised weapons. Here in the United Kingdom, police administration, although marred by many gross defects, is, on the whole, perhaps the best system of civilian peace administration in the world. The system, however, has not kept pace with the times, and of late years there have been many signs that the patience of the public has become strained to the last point of endurance, and that reforms will have to be prompt and thorough in all branches of the criminal executive. The savage sentences of many years of penal servitude constantly passed upon prisoners for trifling offences against property in themselves constitute

a standing blot upon our criminal code. The additional punishment of a man for offences purged by previous penalties is another gross injustice. The whole system of criminal administration and procedure, in short, requires vigorous overhauling and reconstruction in the light of modern humanity and social justice. The shock to the public confidence caused by the revelations of the Beck case must be followed by a reaction of indignation and clamour that will place the British courts of criminal justice absolutely above suspicion. Until recently the vast majority of our countrymen would have scoffed at the idea of anyone being sentenced to two terms of penal servitude and being oppressed by the police for offences committed by another man. The inwardness of the police attitude in continuing the second prosecution with the full knowledge that the identity of the accused in the first trial had been mistaken demands searching inquiry. That there have been many more kindred instances of miscarriage of justice who can doubt? Dr. Bell Taylor, of Nottingham, a gentleman whose testimony may be regarded as absolutely unbiassed and responsible, comes forward with no less than three instances in which his own personal interposition has procured the release of persons from gaol for offences they had never committed. In the first instance, when attending to give evidence he went by accident into the wrong court and heard enough of what was going on to interest him in the case. On medico-legal grounds he came to the conclusion that the accused, who was sentenced to eight years' penal servitude, was innocent, and he ultimately secured the release of the prisoner by the authorities. In the second instance he was taken by chance to the wrong cell in a convict prison, when making a professional visit, and heard enough to convince him the prisoner was being punished for murdering a wife whose death was due to disease. That convict was also released. In the third instance he was struck by the inconsistency of evidence in the account of a criminal trial read casually in a newspaper left on his table. Once more his intervention secured the release of an innocent man. These cases, it must be remembered, were not sought for; they came by chance into the path of a busy medical man. The reflection naturally arises that many more such cases must have come within the knowledge of members of the medical profession. If so, it is surely their duty to speak out, especially now that the time is ripe for setting straight the crooked ways of criminal administration. The first great reform wanted is a court of criminal appeal, of such a kind that every kind of sentence, however trifling, should be subjected to an automatic revision.

**DIET IN RELATION TO DENTAL DISEASES.**

We have in these columns often urged the importance of taking serious note of the wholesale decay of the teeth of the nation. The subject is accorded but scant attention by many to whom

the physical degeneration of the race is a source of anxiety; yet it seems probable that not only are the two questions intimately blended, but that the teeth give the direct clue to much of the ill-health and stunted development of citizens of to-day. The condition of the mouths of the present and of the rising generations is described by some authorities as simply appalling; the abysmal depths of degeneration—we might even say devastation—that the teeth of the British nation has reached is unrealised by those who have its welfare at heart. In giving evidence before the Royal Commission on Physical Training, Dr. Leslie Mackenzie stated that out of six hundred Edinburgh school children examined, five hundred and twenty-one had decayed teeth of the first set, and a hundred and ten of the second set; whilst Professor Hay, in Aberdeen, found that of a similar number of children three hundred and eighty-one had decayed teeth of the first, and three hundred and eighty-eight of the second set. The British Dental Association examined ten thousand Poor-law children, and discovered dental caries in no less than 86 per cent. of them. It may safely be said, then, that the number of persons who reach the age of twenty without decayed teeth must be so small as to be practically negligible. Surely no one can deny that we are here faced with a fact of the gravest moment. This universal destruction of the teeth can be accounted for only by the operation of some universal cause, and that cause should be diligently and persistently sought out and removed. The mouth is the very gateway of the body, and with it in a constant condition of unhealthiness, one must indeed be optimistic or blind to expect sound physique and hearty vigour in the possessor. A thoughtful paper was read by Dr. Sim Wallace at the recent annual meeting of the British Dental Association at Aberdeen on the connection between physical degeneration and dental caries, in which an original line of reasoning was followed with the object of showing that it is to the food of the people that their dental troubles must be attributed. Without committing ourselves to Dr. Sim Wallace's conclusions, we may say that his paper was suggestive, and deserves to be well pondered. He began by pointing out that there is no evidence that the ill-developed classes of society have teeth more susceptible to decay than those of good physical development, but that admittedly conditions of malnutrition and emaciation act prejudicially to the proper growth of the teeth. So long as the teeth are defective it is hopeless to expect physical development to go on satisfactorily. The two developments are intimately correlated. He then dealt with the evils resulting from infected cavities in the teeth and from vitiation of the oral secretions by the products of bacterial action, and showed that much as these undoubtedly lowered the resistance of the mouth and throat to disease onslaughts, an even more serious result is the chronic absorption into the blood of septic matter. In these ways

the lower classes, even though they set out better equipped dentally than their superiors, suffer greater impairment of health, for they are far less careful of their mouths than their more fortunately circumstanced fellows. But the most interesting part of Dr. Wallace's paper was that which discussed the cause of the modern inferiority of teeth to those of our forebears. Dr. Wallace had often been struck by the superior quality of the teeth of those who ate the least soft and refined food, and by the fact that such people possessed better digestions than those brought up on refined and apparently physiologically digestible food. It is his deliberate opinion that food demanding thorough mastication in the mouth is not only best for the teeth but for the stomach and intestines also, and that the early decay of teeth and the sluggish action of the alimentary canal, which is evidenced by indigestion and constipation, are the direct outcome of the habit of eating refined, soft food. Such foods allow the function of mastication to fall into desuetude, and the child, when he finds a lump in his food, falls into the habit of swallowing it whole; the teeth decay and the digestive functions become perverted. All these circumstances lead to a demand for still softer and more nutritious foods and the evils are perpetuated in geometrical progression. Dr. Sim Wallace is prepared to attribute to this unnatural tendency not only dental caries, but also diseases such as appendicitis, rickets, neurasthenia, adenoids, and anæmia. We are inclined to agree with him that the preparation and quality of food used at the present day are some of those circumstances of civilisation that operate differently to what might have been expected. It is a well-known fact that the physiologically perfect products of the laboratory combined in theoretically perfect quantities frequently fail to nourish those to whom they are administered, whilst natural foods that contain much that appears unnecessary and harmful, agree well. No one can regard with pleasure the consumption, now so fashionable, of artificial, concentrated food products, and it is quite possible that the indigestible parts of natural food may have a useful function to perform in the economy. One of these functions may certainly be that of keeping the teeth in healthy order, and, if this be so, while the present dietetic arrangements in the community persist, it is not likely that any amelioration in the teeth of the race will take place. Evidence telling in favour of Dr. Sim Wallace's theory should be eagerly sought, for there must be a good deal capable of being brought forward if it be the true one. At any rate, the whole subject is one of so much moment that no efforts to ascertain the facts should be neglected. Dental caries has been lightly regarded far too long; it is now assuming dimensions that are more or less alarming.

#### THE PRIME MINISTER ON MATTER.

It is, perhaps, useful that the opening address to a conference of men of science should be given



by one who is not himself a man of science. The priesthood of science is, like other ecclesiastical orders, inclined to be somewhat narrow, and to arrogate to itself a dogmatism which is in essence quite unscientific. Absorbed in some particular branch of study, and necessarily heedless of much outside that branch, a man of science is almost bound to lose to some extent his sense of proportion, and this all the more, the more he is absorbed in his work. It always helps to restore, at any rate to some extent, this sense of proportion to hear problems of science discussed by a sympathetic and intelligent outside observer. This is, we think, Mr. Balfour's position as regards science, and we doubt not but that some such considerations as these were in the minds of the members of the British Association when they invited him to become their President. It has been said of the Prime Minister that he cannot discuss any subject without bringing in metaphysical considerations, so that it is hardly to be wondered at that, carefully as he attempted to guard himself, his "Reflections Suggested by the New Theory of Matter," sometimes transcended the limits of physical science. Indeed, it would be hard for any discussion on the nature of matter to be anything else than transcendental, since matter is the *datum* of physical science. Just as mathematics cannot proceed unless certain fundamental principles, to wit, the axioms, are assumed, so, without the assumption of matter as its ultimate principle, is physics non-existent. Mr. Balfour, however, seems to forget that any physical theory of matter, however far back it may explain what we see and feel, leaves matter still there. He seems to give an undue weight to modern discoveries, which have altered our conception of matter by showing that the atoms, which we formerly regarded as ultimate, are themselves composite. "There are those . . . who think that the elementary atom of the chemist, itself beyond the limits of direct perception, is but a connected system of monads or sub-atoms, which are not electrified matter, but are electricity itself." What then? We have merely carried the analysis a little further back and we deal with "monads or sub-atoms," instead of atoms. But how does it help us to call them "not electrified matter, but electricity itself"? We can have no conception of electricity apart from its action on atoms, or monads, or whatever other name we care to give to the units of matter. And by no juggle of words can we do away with this supposition of matter. But like Mr. Balfour we fear we are becoming metaphysical. In the concluding part of his address Mr. Balfour gives an interesting explanation, based on the principle of natural selection, of the inevitableness of our shortcomings in the field of knowledge. "So far as natural science can tell us, every quality of sense or intellect which does not help us to fight, eat, and to bring up children is but a by-product of the qualities which do. Our organs

of sense-perception were not given us for purposes of research, nor was it to aid us in writing out the heavens or dividing the atom that our powers of calculation and analysis were evolved from the rudimentary instincts of the animal." As this is true of our perceptive faculties, so much more is it true of our speculative powers, and the fact goes far to explain to us the limits of our powers. Rightly understood, however, a knowledge of our limits should not be an incentive to pessimism, since it helps to guide us to a useful activity. At the same time it teaches science and philosophy alike that they have limits which they cannot transgress. "There are more things in heaven and earth than are dreamt of in your philosophy" seems to be the lesson Mr. Balfour wished to impress on the members of the British Association, and through them on students of science generally.

### Notes on Current Topics.

#### Scarlet Fever and Hospital Isolation.

IN the present issue of THE MEDICAL PRESS AND CIRCULAR we publish two important articles dealing with the hospital treatment of scarlet fever. For some years past the belief has existed that the system of hospital isolation has not proved a success so far as the diminution of incidence or of case-mortality has been concerned. The writer of one of the articles mentioned, Dr. Killick Millard, has been one of the earliest and most persistent critics of isolation hospitals in regard to scarlet fever. One of his chief contentions appears to be that the isolation hospital fails to isolate. Our second writer, Dr. H. Biss, contributes a full and scholarly article, of which the first part deals mainly with the impossibility of diagnosis of anomalous cases of that specific infection, where the characteristics of rash, sore throat, temperature, may be altered beyond recognition or altogether absent. Under such circumstances it is clear that it would be impossible to devise an absolute system for the notification of all cases of the malady. It follows that any form of isolation would be impossible, because many cases would escape identification. The superiority or otherwise of hospital over home treatment of the disease forms another branch of the discussion. Readers of these excellent articles will doubtless bear in mind that the majority of public health authorities maintain that the hospitals furnish the only possible solution to the problem of how to deal with scarlet fever.

#### A Bacteriological Institute in Madras.

THE subject of tropical medicine offers a wide and, to a great extent, unexplored territory to the scientific investigator. The enormous social and economic importance of this special branch of knowledge can only be dimly realised. Hitherto it has been customary to reproach the medical profession in tropical countries with the laxity and the conservatism of their scientific methods.

The brilliant discoveries of recent years, however, have done much to wipe away that reproach. At the same time it may be generally asserted that the level of scientific public health administration in our tropical colonies is still in a backward state. In India, for instance, in army as well as in civilian life, the facilities for bacteriological research were non-existent, and the only work done in that direction was that of a small knot of scientific enthusiasts. Nowadays all that is changed. The keynote of present medical administration in India is the predominant necessity of the bacteriological and the chemical laboratory. One of the most recent additions to the strength of the advanced scientific army in India is the King Institute in Madras. By the energy and persistency of Lieut.-Colonel W. G. King, C.I.E., I.M.S., a fully-equipped Government laboratory has been established in Madras. The departure is full of interest, as it furnishes an example not only to all British colonies and dependencies, but one that may suggest serious reflections to sanitary administrators in the United Kingdom. An account of the King Laboratory work will be found, by Colonel Christophers, among the Original Communications.

#### Another Drink Cure.

It is a thousand pities that ministers of religion, in common with many other well-meaning people, take so little trouble to enlist the sympathies of the medical profession in many of their philanthropic schemes. They cannot be unaware of the enormous amount of charitable work cheerfully performed year in and year out by medical men, and if they would take the trouble to inquire into the subject they could easily find out why the medical profession preserves the code of ethics laid down by Hippocrates. That code is the guarantee to the citizen that in consulting a medical man his highest and best interests will be scrupulously respected. Yet ever and again we find clergymen deliberately flouting all that the medical profession hold dear, and, from mistaken motives of philanthropy, running counter to those traditions that should be regarded as inviolate. The vicar of St. Luke's, Camberwell, the Rev. Hugh B. Chapman, has been stirred by the wonders of some drink "cure" to start a campaign to exploit this remedy on his own account. We have no knowledge of Mr. Chapman. However willing we may be to believe in the personal disinterestedness of his action, we cannot condemn in too strong terms the form that his appeal has taken. Two months ago he wrote to the press, saying "that he had come across a striking remedy for dipsomania, and since then he has had 1,800 letters of inquiry on the subject." With the rashness of a tyro he has himself undertaken the treatment of eleven most distressing cases, need we say, with complete success? So great is his confidence in the "remedy" that he has now written to the lay papers again, asking that all applicants for relief from alcoholic habits should communicate with him, and that he will be pre-

pared to undertake their treatment. The generous proprietor of the "cure"—"a purely vegetable drug, guaranteed perfectly harmless"—has placed a supply at Mr. Chapman's disposal for a nominal sum, seeing, no doubt, a splendid advertisement for his goods by so doing. Mr. Chapman admits that his object is to bring this remedy within the reach of all and secure it for the common good. Has he, we wonder, acquainted himself with the life-history of a hundred and one of these "drink cures" that have had their little day, and disappeared when their credit was gone and their owners sufficiently enriched at the hands of their victims? Mr. Chapman should know that the medical profession refuses to prescribe esoteric drugs that are exploited as private ventures, because it considers such a proceeding detrimental to the interests of its patients, and because secret remedies, like secret societies and secret dealings of all kinds, are contrary to public policy.

#### A Strange Congress.

MAN is a gregarious animal. Whenever opportunity offers or excuse admits, he foregathers with those of his fellows to whom he is bound by some tie, real or imaginary. Every species of humanity has its club, its congress, its annual dinner. Sometimes such gatherings are organised on the plea of mutual edification; at other times frankly on that of good-fellowship. But the general result is usually a "good time." A curious *réunion* in Paris was that lately called into existence to promote the interests of, and cultivate friendly feelings among, fat men, the qualification for entry being the possession of so many stones of bodily weight. Surely, however, a stronger aggregation never took place than that recently held at Coney Island to welcome "graduates" reared by infant incubators. To this congress repaired no less than fifty infants and young children who owed their presence on earth to the invention of Dr. County, including in their ranks the famous Cohen triplets, now in the blush of their third summer. These latter infants were born in a tenement house in New York, and together weighed at birth as much as one healthy child, but after a process of incubation at the Pan-American Exhibition at Buffalo, they all managed to attain presentable proportions. Dr. Wallace Lee, who first installed the system of incubation at the Omaha Exposition in 1897, told the assembled crowds that whereas 97 per cent. of the class of infants now successfully reared by the incubators used to perish before their introduction, up to the present he had only lost thirteen out of a hundred and twenty-six. In this year's infant colony at Coney Island there are no less than three sets of twins and one of triplets, all flourishing. The proceedings of the Congress were apparently marked by great cordiality, but in the report of the meetings it is not mentioned that any of the "graduates" related the experiences of his early up-bringing. Perhaps they are being reserved for some imaginative novelist. At

any rate, the time passed pleasantly, and if the *menu* of the annual dinner was a simple one, it was probably better suited to the digestive organs of the guests than the elaborate concoctions of French *chefs* usually are.

#### Neurosis of the Œsophagus.

THE functional diseases affecting the Œsophagus have not received much attention from clinical observers, probably on account of their comparative insignificance. Nevertheless, many distressing morbid conditions may result from neuroses of this portion of the alimentary canal. The so-called "globus hystericus" is, perhaps, the most familiar of all functional disturbances of the Œsophagus, and one which is specially associated with hysteria. The sensation of something slowly rising in the throat which threatens to choke the patient is a symptom at once seized upon by the physician as proof positive of the existence of functional nervous disorder, and valerian and assafoetida are forthwith prescribed. Knott, in his classic monograph upon the subject, states that the phenomenon of globus is directly produced by spasmodic contraction of the muscular fibres of the gullet, though he does not specify which layer. Dr. A. L. Benedict has found that spasm of the Œsophagus may be induced physically, as, for instance, by attempts at swallowing when the throat is dry, or by cutting short a fit of laughter by sudden deglutition. In states of passion or great emotion the functions of the Œsophagus are often much perverted, swallowing being sometimes absolutely impossible under such circumstances. Cases of spasmodic, intermittent dysphagia have been described by Graves, Paget, Brinton, and others, in which there was not the slightest evidence of any hysterical condition, but the subjects were neurotic. The recognition of such cases is a matter of no small difficulty as they sometimes occur in elderly patients in whom the suspicion of malignant disease may be entertained. The cautious exploration by means of the Œsophageal sound will determine the presence or otherwise of obstruction, and in functional cases the mere passage of the instrument may have a curative effect.

#### The Wisdom of Swimming.

WE teach in our public schools much that is useless for the true development of the mind and, it may be, in many cases, actually damaging to the body. Our sins of commission are great, but our errors of omission are greater. At this season of the year the desirability of making swimming a compulsory part of school training is occasionally discussed, but the fact remains that a vast number of our school children are altogether devoid of any knowledge of the art of swimming. It is true that many excellent public baths are springing up in cities and urban districts, but the greater number of the smart towns and villages of our country offer no facilities for swimming, and even opportunities for bathing for cleansing purposes are scanty. We contend that

in the interests of the physical development of our people, and as a wise, prophylactic measure for the safeguarding of valuable human lives, swimming should be made a compulsory element in every public school education.

#### Life Losses on the Alps.

THE Alps have been well called "the playground of Europe," but for many a life rich in distinction and promise for humanity they have proved the graveyard. This year the number of mountaineering disasters has been exceptionally large. Some of the accidents are such as may be considered inseparable from the risks of high sport, but many others are the outcome of recklessness. The neglect of elementary principles of hygiene, the excessive exertion of untrained bodies, the absolute lack of mountaineering knowledge, lose many a valued life. And warning is needed by all sorts and conditions of men and women. We write from personal knowledge of the ways of the average Englishman and Englishwoman when the keen glacier air has whetted the natural appetite for feats of strength and endurance. Many a teacher and many a student seek recreation among the mountains without a thought or care for their own fitness for the exercise proposed. Ropes are tested and axes examined, but the climber rarely thinks it necessary to wait for a physical examination into his own powers of endurance or ability to meet the stress and strain of prolonged exertion. It is useless to agitate for a study of hygiene in our schools if the teachers neglect the first steps to secure a rational method both of work and of play. The heavy death roll of the mountains during the past few weeks is sufficient argument for our contention that a thorough medical examination should be made of everyone who intends to woo the delights and dangers of prolonged exertion among the beautiful evil Alps.

#### The Treatment of the Summer Diarrhoea of Infants.

THAT veritable scourge among the infantile population, summer diarrhoea, has once more appeared in our midst coincidentally with the fall of the atmospheric temperature. In many localities, it is already alarmingly prevalent, while in certain districts of the metropolis it seems to be of an unusually virulent type. One curious point about the disease is its deceptive character, for many severe cases are discharged from hospital as convalescent, only to undergo a sudden and rapidly fatal collapse. The reason for this is somewhat obscure. Of all the methods adopted for the treatment of this complaint, none can be considered truly specific. The administration of drugs must be influenced by the clinical features that predominate in a given case. In those which present a parched skin, hyperpyrexia, and much restlessness, small doses of opium in the form of the aromatic chalk powder are indicated, but as the whole system is suffering from the effects of loss of fluid, rectal or subcutaneous injections

of normal saline or fresh sheep's serum are often of signal benefit. Warm baths are useful in almost all cases. Many physicians pin their faith to an initial dose of castor oil or grey powder followed up by such intestinal astringents as tannic acid or bismuth. Others prefer to administer intestinal antiseptics, such as the sulphocarbolate of zinc or the salicylate of bismuth. Alcohol is generally given as a stimulant, though it is questionable if minute doses of strychnine would not be more beneficial. Lavage of the bowel is one of the most important of the more modern therapeutic methods. Milk feeding is better dispensed with altogether from the first, its place being taken by albumen-water or whey. When the acute condition has subsided, small quantities of raw meat-juice may be given with advantage, a gradual return being made to milk.

#### Concerning Quacks.

"THERE be three things which are too wonderful for me—yea, four which I know not." If the wisest of men had lived in modern days he would have found it necessary to extend his list considerably, for even he could not have comprehended the infinite variety of wiles and dodges by which mountebanks manage to prey on the credulous. We suppose it is because the wings of the American eagle are so broad that that land of the free has become the special home of quackery and charlatanism. At any rate we think there is no other country in the world which could boast such a variety of gross superstitions at the present day as those to which Professor Osborne of Yale has drawn attention in a recent address. (a) With some of these, such as Eddyism, Dowieism, Osteopathy, we are more or less familiar in these countries, though happily the attempts to gain many converts have been so far unsuccessful. Of others we know less, and it is with some surprise that one finds what a thriving profession that of miraculous healer may be in the States. Thus, one "magnetic healer," who undertook to heal by absent treatment, was for some time in receipt of an income of five hundred pounds a day in fees of one pound per case. Another gentleman, established in Chicago, promises by the exercise of forceful thought addressed to disease germs, to drive them from the bodies of the sick for fees varying from two to fifty dollars a head. We learn, too, from Dr. Osborne, of the existence of a cult called "Ralstonism," which "is the lever that has been designed by the Creator for the work of uplifting the world." The Ralstonites are, however, an exclusive sect, and keep their positive doctrines secret. Among the more weird cults are mentioned many at whose tenets or methods we cannot even guess—Phenopathists and Venopathists, Cereopathists and Chiroprathics, Viticulturists and Vitaphysicists, Somatotherapists and Esoteric Vibrationists, the Koreshan

Universology, the Fire-Baptized Holiness Association, and, lastly, The Holy Rollers.

#### Sentimentality Among Guardians.

EVERY year or two notices a sudden outbreak of sentimentality among guardians of the poor with regard to the disposal of the bodies of those who have died while under their care. One does not notice an equal anxiety as to the comfort of those who have not yet died. From time to time, however, some guardian discovers with a feeling of pained surprise that the bodies of the unclaimed poor are made serviceable for anatomical purposes, and he immediately exerts himself to prevent such a "scandal." It is only a few months since an attempt of this sort was made in Dublin, and the other day there was a warm debate among the Hull guardians following on the discovery by one of their number that unclaimed bodies were occasionally sent to Cambridge for dissection. It is curious how difficult it is to convince people that the supply of bodies is a necessity of medical education, and that the ultimate object of medical education is the treatment of the sick and not the aggrandisement of the physician. And if medical education of proper sort be lacking, it is not the rich but the poor who will inevitably suffer. The rich can obtain the best medical advice, wherever it has to be brought from, but the poor must be content with what is at hand. Guardians of the poor have surely enough serious business with which to occupy their time without devoting themselves to the resuscitation of injurious and meaningless superstitions.

#### Physical Deterioration Committee.

THE appendix just issued to the report of the Committee on Physical Deterioration contains much valuable information, and though some of the returns therein presented are more imaginary than one had been led to expect, others give cause for grave anxiety. Thus one finds that at St. George's Barracks, London, where nearly one-third of all recruits are examined medically before enlistment, 374 per 1,000 are rejected as unfit, while in Manchester the proportion is even higher, namely, 490 per 1,000. The standard for recruits is not a high one, and it is significant that in two of the largest centres of industry nearly a third of presumably healthy young men cannot attain to it. Curiously enough, in Birmingham and Edinburgh the returns were much more favourable, only 192 failing in the former town, and 173 in the latter. Whilst in Edinburgh it is comprehensible that a large number of countrymen may present themselves for army service, and thereby raise the general level of fitness among the applicants, it is difficult to understand the marked difference between Birmingham and Manchester, unless it depends on the personal equation of the medical officer. The effect of good hygienic conditions on the physique of children is well shown in a set of tables prepared by Dr. Eichholtz, in which he compares the elementary school children of

(a) *Journ. Amer. Med. Assoc.*, July 2nd, 1904.

the open, healthy suburb of Wandsworth with those of the slum district of Lambeth. At four years of age the Lambeth children are on an average about seven inches shorter than the Wandsworth ones, and at fourteen years, three and a half inches. The lamentable fact is brought out, the poorest class of Lambeth child is worse developed than similar children in other large towns, such as Manchester and Leeds, and the difference between the poorer and richer classes is marked indeed. There is, however, one comforting fact, namely, that from photographs taken of children attending Lant Street Board School in the Borough in 1875-78, evidence is forthcoming to show that the physique of the poorest class of children is somewhat better to-day than it was twenty-five years ago. The whole of this appendix tells one decisive lesson—physical development depends on hygienic conditions of life.

#### Infantile Alcoholism.

THE gradual spread of the temperance movement in this country and the consequent lessening of disease due to alcoholism are matters for universal satisfaction. It is somewhat disquieting, however, to learn that in certain quarters parents are so little alive to their responsibilities as to give alcohol to babes and sucklings. For instance, the evidence at a recent inquest upon a boy of four showed that he had a regular allowance of beer. This child ultimately died of alcoholic poisoning as a result of drinking a mixture of rum and beer. It is well known that gin, or other strong spirits, is sometimes given to infants at the breast to "settle the milk," as it is thought, but really for the purpose of pacifying fretfulness. Can it be wondered that serious internal mischief is produced, to say nothing of damage to the nervous system which at this period of life is particularly susceptible? According to the *Alliance News*, the children of Normandy are in a very bad way. At a tender age they are given eau-de-vie, or "calvados," a spirituous liquor allied to gin, while brandy is frequently included in the daily rations of school children. The writer has there seen little girls intoxicated in the afternoon, utterly unfit to pursue their studies. We are glad to think that such a disgraceful state of affairs is not permitted in this country, though among the poor it is to be feared that infantile alcoholism is prevalent to a greater extent than is usually believed. More beer is drunk, unfortunately, than milk, and this latter commodity is often so diluted with water as to be of little real nutritive value. There is still much scope for tactful visitation by ladies and other workers who, by simple and kindly precept, will convince parents of the folly and wickedness of giving strong drink to their offspring.

#### Pneumonia and Public Health.

THE appointment by the New York Board of Health of a Commission of Experts to inquire into the prevalence of pneumonia in that city draws public attention to the ravages made by that

disease. We are so accustomed to regard tuberculosis as the principal foe which attacks the chest, that it comes on us as a shock to find that in several large American cities the deaths from pneumonia during the winter half of the year are more than double those from phthisis. In considering this proportion, however, it is to be remembered that the death-rate from phthisis is much lower than it was some years ago, owing to the success of preventive measures, and the question at present is whether pneumonia can be tackled with equal success. The case of the two diseases is very similar. Each is dependent on a special organism, which for its growth and multiplication requires a particular soil. *A priori*, there are two methods of attacking such a disease. We may either attempt to produce a soil where the organism cannot grow or we may attempt to eradicate the organism itself. In neither of the two diseases we are discussing can we apply the first method further than by developing a state of general good health. Our principal attack must be directed, therefore, against the organism itself, and the means adopted will be similar in the case of pneumonia to those that have been so far successful in the case of tuberculosis. Every attempt must be made to prevent the spread of infection by destroying with rigour all material where the *contagium vivum* may lurk. Nor will it be necessary to destroy the sputum of the obviously sick, but strictest regulations against expectoration in public places must be enforced. This is impressed on us all the more by the fact that many minor ailments, such as rhinitis and tonsillitis, are in causation pneumococcal, and infection from them may start a typical pneumonia in other persons.

#### Stature and Sickness.

AMONG physical characters there are few, perhaps, which influence the incidence of disease to such an extent as the stature of the individual. Those folk who quarrel with their height and devise some fresh means for altering it hardly realise the system of compensation which may be traced everywhere in Nature. In attempting to add cubits to their stature they ignore the fact that the balance of the whole being may be endangered by so doing. An interesting paper upon this subject was read before the British Association at Cambridge by Dr. P. C. Shrubbsall, who stated that individuals of high stature were more likely to be affected by heart disease, rheumatism, and tonsillitis, whereas short people were more often found suffering from tuberculosis, cancer and nervous diseases. Such generalisations have not, of course, been made without careful observation and measurement of a large number of patients, though it may not appear at first that there is any special connection between stature and disease-incidence. From the life assurance point of view the height of the proposer may influence considerably the decision of the medical examiner. Most authorities, for instance, are

agreed that if the stature exceeds five feet ten inches there is an increased risk, chiefly from heart affections. More than usual care should, therefore, be taken over the physical examination of the vascular system in a very tall subject, for it is well known that such people do not bear sudden strain or prolonged physical exertion at all well. The proportion between the height and the weight is even more important than the former alone. It may be advantageous at times to be head and shoulders above one's fellows, physically speaking, but a giant's stamina is not commensurate with his stature; indeed, the contrary is more often the case.

#### The Hygiene of Slavery.

EVEN the most rigid of New England moralists has had to admit that the emancipation of the slave has not been an entire success. It is true that in the emancipation a great principle of right triumphed, but principles have often the drawback of being injurious in their application in some of their details. Hence it is that the negro question in the States was by no means settled with the close of the Civil War. It is still the most serious social question in America, as the constant reports of alternate outrages and lynchings show. One of the lesser deleterious effects of the abolition of slavery, but one of particular interest to medical men, is the increased vulnerability of the negro race to certain diseases. Of these the most important is consumption, which has increased among the emancipated population to an extraordinary extent. Under the system of slavery the incidence of consumption on the black and white populations of the South was practically identical. At the present time to quote the figures from Charleston, while the incidence on whites has diminished by about twenty per cent., that on blacks has increased by 230 per cent. As regards insanity, the tale is similar. Previous to emancipation there were, as a rule, about sixty coloured patients in the Eastern Hospital for the Insane, Virginia, whereas now there are over 1,000. The cause of these changes is obvious enough. As slaves the negroes had to live regular, methodical, and, on the whole, healthy lives. Their houses were comfortable, their food good, their clothing sufficient. If sick, they had prompt medical attendance. They were, in fact, valuable living chattels, and as such their owners took care that their lives were rendered as sound and useful as possible. Now-a-days, however, they must shift for themselves. They are in the midst of a civilisation which they cannot understand, for which they are quite unfit. Overcrowded, lazy, dissipated, drunken, and ignorant of the evils resulting from such habits they are rendered an easy prey to tubercle. Formerly the negro had no need to think for the morrow—all was provided for him. Now his mind is subjected to the stress of competition in the most advanced civilisation of the world, a civilisation alien to him, and yet in which, if he is

to survive, he must take his place. It is no wonder that such conditions have conduced to the fearful increase of insanity above noted.

#### The "Live" Rail Peril.

THE convenience of rapid transit nowadays is not without its drawbacks, especially where electricity is concerned. It is, no doubt, an immense advantage to be conveyed swiftly from the suburbs to the city and *vice versa*, but with fresh forces fresh dangers have arisen. Several fatalities have lately occurred owing to contact with the so-called "live" rails upon railway lines, and the inquiry instituted by the Board of Trade has shown that the danger is by no means a theoretical one. It has been stated that the voltage of current upon the Metropolitan "tube" railway is not sufficiently high to produce a fatal result through mere contact. Death from shock ensues only when the body completes the circuit between the "live" and the running rail, and even then it would be necessary for the current to pass for an appreciable space of time. The fatal cases examined by Dr. Oliver and reported in the *Lancet* show that the burns inflicted by contact with the current-bearing rail are deep in extent, and of an unusually necrotic type. The question of protection of "live" rails is one which must be considered seriously by the railway companies and municipal authorities, and though it is impossible to cover in the rail throughout its whole length, yet adequate protection should be secured for the public at all accessible points. It is satisfactory to learn that guard rails are now being affixed upon the Underground Railway wherever a "live" rail, which is placed at the side of the track, is exposed to view. Another danger exists in the case of the electric tramways from the risk of the overhead "live" or trolley wire breaking. When such an event occurs, which happily, is not frequent, it is again necessary for the circuit to be completed *via* the human body before unpleasant consequences ensue.

#### PERSONAL.

It is not generally known among the medical profession that the speaker of the House of Commons is the son of a medical man, the late Mr. James Manby Gully, M.D., of Great Malvern.

THE new rector of Berlin University for the coming year is a member of the medical profession, namely, Professor Oscar Hertwig, Director of Medicine and of Philosophy, and Director of the Anatomico-Biological Institute, and member of the Academy of Science of Berlin.

THE British Association is going somewhat far afield for its next meeting, which is to be held at Capetown, under the Presidency of Professor George Darwin, of Cambridge.



MAJOR RONALD ROSS, C.B., F.R.S., has received the distinction of being elected Foreign Corresponding Member of the Paris Academy of Medicine.

A SIMILAR recognition of professional eminence has been conferred by the Academy upon Dr. Weir Mitchell, of Philadelphia.

PROFESSOR TILLAUX, President of the Paris Academy of Medicine, has been created *Grand Officier* of the Legion of Honour, by the President of the French Republic, who is himself a medical man.

THE appointment of Dr. J. E. M. Brown to be a District Surgeon in the service of the Federated Malay States has been confirmed.

DR. C. G. CASSIDY succeeds Dr. A. Bain, who has been transferred as Medical Officer in Charge of the Empanyana Leper Asylum, Cape of Good Hope.

MR. C. M. TUKE has been elected President of the West London Medico-Chirurgical Society for 1904-5.

THE resignation by Dr. Boyd of the Medical officership of South Shields, has created a vacancy for which there are now six selected candidates.

Miss McCaul and Miss Elaine St. Aubyn who, under the personal sanction of the Queen, went out last March to Japan to inspect and report upon the Japanese military nursing both in the field and at the base hospitals, are returning to England in the P. and O. steamship *Sardinia*, which is due at Tilbury on September 5.

### Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENTS.]

#### SCOTLAND.

A GOVERNMENT CAUTION AS TO VACCINATION CERTIFICATES.—A memorandum as to the granting of certificates of successful vaccination has been issued by the Local Government Board, in which it is stated that the Board have had their attention drawn to the statements made in the reports of medical officers of health regarding cases of small-pox in children who presented no evidence of successful vaccination, either in the presence of local scars or in modification of the disease, although said by the parents to have been vaccinated. Similar cases have been observed in the course of inspection of contacts. Further inquiry showed that in many such cases a certificate of successful vaccination had been lodged with the registrar. The Board are satisfied that considerable laxity exists in the granting of such certificates, in respect that they are not always founded on personal inspection of the child after a sufficient interval, and occasionally have even been signed at the time of the operation, when its result was unknown, and when subsequent inspection would have disclosed failure. The certificate bears that the operation was performed by the person who signed it, and that it has succeeded, and if in either respect the certificate is false the signatory is liable to a criminal prosecution. A case which occurred in 1872 is quoted in which a sentence of four months' imprisonment was imposed on a practitioner who granted certificates of successful vaccination, though the vaccination had not taken effect, and the Board desire to make it publicly known that if in future any case of this nature comes to their knowledge, it will be their duty to report it to the Crown with a view to proceedings being taken.

#### BELFAST.

PUBLIC SANATORIA FOR PHTHISIS.—The question of consumptive sanatoria is much before the Belfast public just now, being discussed in the Municipal Council, in the Board of Guardians, and in the local

press. The Corporation has already decided to provide a sanatorium, and sites are being examined for the purpose at present. The Guardians have now decided that they also will provide a sanatorium, if the Local Government Board will permit, and have asked leave to purchase a house and grounds known as the "Abbey," at Whitehouse, some four miles from the city, on the north side of the Lough. Two strong objections have been raised to their proposed action: First, that they ought to combine forces with the Corporation and not attempt to run a separate sanatorium; and second, that if they do decide on a sanatorium of their own, the proposed site is unsuitable. As regards the first point, there can be no doubt that two sanatoria will cost more than one, and the ratepayers must find the difference. The Corporation propose to start with a scheme for 100 patients, and are willing to take patients from the workhouse at a fixed rate of payment, provided they are considered curable. The Guardians say that the Corporation scheme is too small to be of use, as they themselves have usually 200 to 300 consumptives in the workhouse infirmary. Further, they say that they must make provision for all cases, curable or otherwise, and difficulties would arise in selecting those for treatment in the Corporation sanatorium. As regards the question of site, if it is decided to provide a workhouse sanatorium, the "Abbey," though not an ideal site, is probably as good as could be found. It is true that it is on a cold clay soil, not well drained and near the muddy shore of Belfast Lough, but it is 160 feet above the sea, has a south aspect, some trees to shelter it on the north, and it is cheap.

THE SMALL-POX OUTBREAK.—The general outbreak of small pox which threatened Ulster a fortnight ago seems to be passing off without doing much damage, due no doubt to the very vigorous means which were adopted to combat the disease in every town in which it appeared. After Belfast, the worst outbreak was in Armagh, where twenty-one cases occurred, five being severe confluent cases, eleven discrete, and five modified. As the accommodation was insufficient, a shed divided into two wards each to contain fifteen patients, was built at a cost of £200. No fresh cases have appeared in Omagh, Monaghan, or Enniskillen. Three severe cases are under treatment in Castleblaney workhouse. As is always the case, the scare is having some excellent results. For one thing, the inhabitants of the districts where small-pox has occurred are flocking in hundreds to be vaccinated. Then it has led the Guardians in many of the country towns to set their houses in order, and carefully consider the accommodation available if cases should occur in their district, for whatever shortcomings the ratepayers may overlook, they will certainly not forgive any slackness in dealing with small-pox. It is extraordinary how strong the dread of this disease remains, in spite of the fact that generations have passed away since it devastated the country.

### Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—While weighing the gage thrown down by Dr. Taylor with a view to testing the justice or otherwise of his challenge, up rushes LL.D. with lance pointed and vizor down. This anonymous champion straightway assails me fiercely, not as a neutral critic, but as Dr. Taylor's sworn foe. Let us see what wounds he has inflicted.

On p. 33 of your issue of July 13th, I said, "In 1884 the total birth-rate (of the United Kingdom) stood at 31." It should have read: The average of the five-yearly period, 1884-1888, stood at 31.2. To refute my figures for the United Kingdom Dr. Taylor quoted the returns for England and Wales in 1884. That error is rendered none the less

grotesque by LL.D.'s showing that my figure of 31 for the total birth-rate of 1884 is wrong. LL.D. strikes wide, however, when he says that my argument "founded on the assumption that the birth-rate in 1884 was only 31, therefore falls to pieces." That is true so far as it goes, but the main argument of that part of the article is independent of the figures 31. Accepting LL.D.'s correction, I see no reason to alter my very mild and moderate conclusion as stated in the following passage: "My figures, I am aware, may not be absolutely accurate but I think it may be safely concluded that the fall in the *married* birth-rate is much less than that shown by Dr. Taylor. In a word, his figures are vitiated at the outset by his failure to consider the facts of the extra-marital condition of illegitimacy. It is impossible, therefore, to accept his (Dr. Taylor's) fundamental proposition that 'we may take the birth-loss in the United Kingdom as due to causes operating in the married life of its inhabitants.'" Let LL.D. justify Dr. Taylor's logical blunder if he can; it will not be done by pointing to a fortunately non-essential blunder that has crept into my article.

Dr. Taylor shows an equal misconception of what I say when he wrote on August 10th, that I "build my main argument on the 1884 rate being 31." I do nothing of the kind. I assure both him and LL.D. that the single one of my various arguments concerned is so little affected by the figures that I am willing to cut out of the passage in my article (p. 32 MEDICAL PRESS AND CIRCULAR.), from "his figures," down to "condition of illegitimacy."

My abandonment of these figures disposes of LL.D.'s further attack on my estimate of what would happen had there been no decline in the rate of illegitimacy. I am not an advocate on one side or the other, and am open to correction. The fallacy is self-evident of Dr. Taylor's assumption that the decline in the birth-rate is due to causes affecting married life, when he fails to consider the illegitimacy included in the total rates.

Lastly, the social and economic conditions are so absolutely different in New South Wales that conclusions founded on an investigation there would have little application to the United Kingdom. In New South Wales, for instance, there is universal suffrage, and members of Parliament are paid for their services. These two facts alone will show the vast gulf between the two countries, which I still maintain may be described by the homely comparison, familiar enough in my own Western county, of the difference between chalk and cheese. I have often noted how the simple directness of hobnailed philosophy nettles those who love subtleties and sweeping generalities rather than rigid logical analysis.

Why does not LL.D. come into the light of day and let us know who he is? Surely he is not afraid of injury to some great reputation and authority? To my mind no man, without signing his name, has any right to pen such a sentence as that of LL.D.'s when he says: "The loose way in which Dr. Walsh handles figures puts him almost outside the pale of statistical controversy." The question naturally arises, who put LL.D. inside that pale? There is only his letter to judge by, and at the end of it we find our old, old friend, the *petitio principii*. In accusing me of favouring a policy of "smug complacency," LL.D. simply calls names where he should furnish formal proof. This question-begging shows that whatever his years and experience he does not always observe the rules of sound argument. If he can produce a "crushing refutation" to my "fallacies" such as he says is to be found in the Report of the New South Wales Commission, I shall be the first to welcome his exposure, provided it stands the tests of formal critical examination.

I am, Sir, yours truly,  
DAVID WALSH.

Hanover Street, London, W.  
August 26th, 1904.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—Will you allow me to answer the questions submitted by your correspondent "Qualified Assistant?" On consideration, it must be obvious to him that the special question whether "A" or "B" did right to marry, must depend on many reasons—on their age, education, characters, habits, and circumstances, and in the cases before us I have altogether insufficient data on which to form an opinion. But whether married or not, I do hold that strict temperance in all allowable sensual gratification, and abstinence from that which is inallowable, is right and good, not only for the individual, but for his or her future progeny.

Such principles carried out in practice will not result in too early marriage nor in the production of the greatest possible number of children, but should result, I believe, in the moral growth of the individual, and, if married and fertile, in vigorous, healthy, and sufficiently numerous offspring.

Applying such principles to the particular cases cited, I hold that even a country practitioner and a poor curate cannot be justified in using artificial means to prevent conception.

Particular cases may labour under unjust disabilities which demand redress, but two wrongs will not make a right.

The common labourer, in our great cities (as Mr. Rowntree has shown), is too often not paid a living wage, sufficient for himself, his wife and a family of four children, but is underfed, under-housed, and underclothed. This is sad and shameful, but (if it were possible) it would be a poor remedy to sterilise the labourer or limit his family to one. The injustice of insufficiently paid labour would be thereby perpetuated.

Similarly, in many cases the stipends of the clergy, and especially of curates, are deplorably and disgracefully inadequate. As the world is at present constituted, the practical philanthropist must hope that all these cases of injustice will force themselves more and more on the notice of the people until they refuse to grow rich or comfortable or instructed on the enforced charity of those that serve them.

It is no true remedy for the clergy to sit down under their grievances, and to practise and encourage an unnatural sexual life which must be more or less degrading and carries with it no real element of cure.

Such a course will only perpetuate injustice and lower the general ideal of religious life among both clergy and laity.

Exactly the same principles, I believe, apply to the nation as to the cases I have considered. Let us admit that England is too small for the genuine natural increase of its population. It is the coward at heart who, because of this, will resort to methods of sexual congress "habitually adjusted to a certainty of imperfection." Rather should he busy himself in establishing schools of emigration in which his children shall be fitted for pioneer life—in finding new markets for his goods, and in bringing reliable knowledge and assistance to the very doors of the youthful and enterprising. It may well be doubted whether the higher ideals I am striving to preach do not demand some alteration in present economic conditions—a change in the direction of greater equality in the distribution of wealth. If so, let us attack the problem bravely and seriously. To fold our hands and avoid present pain at the cost of future decadence, is a miserable and destructive policy for the nation as well as for the family.

I am, Sir, yours truly,  
JOHN W. TAYLOR.

22, Newhall Street, Birmingham.  
August 25th, 1904.

#### MEDICAL GEOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—Geology is a wide science. To some the various strata of our earth's cortex is of interest, and

their relation to each other, and the forces that have disturbed them. The chemist, the mineralogist, and the engineer may have to study some branch of geology; and there is no doubt but that some knowledge of geology should be possessed by the members of the medical profession. When we are analysing the climatic character of any country or locality, the first thing to look to is the nature of the soil. In England the differences are great. We may find two places on parts of our coast where temperature, rainfall, sunshine, and other external influences are much the same, but where the conditions of the atmosphere differ much. Now that the question of open-air treatment of lung diseases is of interest, it would be well to be careful to study the soil, as upon that so much depends. It would be well for doctors to know the differences between clay, chalk, greensand, and Silurian, geologically, chemically, and medically. Without such knowledge, we are not competent to deal properly with the wide question of climate.

I am, Sir, yours truly,

R. L.

## Obituary.

SURGEON-MAJOR FRENCH, M.B.ED.,  
M.R.C.S.ENG., L.R.C.P.

MAJOR GEORGE BROOKE FRENCH, of the Indian Medical Service, who died last week at Tunbridge Wells, was a graduate of the University of Edinburgh. He obtained his M.B. in 1894, and was prizeman in a number of subjects and took first-class honours in many others. He was also gold medallist in medical jurisprudence and prizeman in surgery in the Edinburgh School of Medicine. He qualified as a member of the Royal College of Surgeons, England, in 1885, and as a licentiate of the Royal College of Physicians, London, the following year, in which he joined the Indian Medical Service. In 1891 he took part in the expedition to Manipur, for which he had the medal with clasp; and in September, 1898, became a Major.

## Literature.

### PHYSICAL DETERIORATION.(a)

It is a significant fact that the progress of civilisation is fraught with disadvantages to the lower strata of society, which, it is to be feared, more than compensate for the ethical evolution and enhanced comfort of the more favourably situated members of the community. In spite of philanthropic and municipal efforts overcrowding proceeds apace, and the sanitary condition of our slums is the despair of sanitary experts. Here and there one perceives a ray of light, authorising the hope of better times ahead, such, for instance, as the spread of the sanitary gospel of fresh air, the importance of cleanliness and so on. But we are confronted with the fact that a large proportion of our labouring population live and move and have their being under conditions which render fresh air and personal cleanliness physical impossibilities. It is estimated that 3,250,000 persons in the British Isles live in overcrowded dwellings, that is to say, with an average of three persons in a bedroom; we are told that in York, for instance, 228 houses have between them only 33 closets, while 442 have only 30 water-taps, the tap often being placed in the wall of the w.c. How are people to get fresh air in a climate like ours with an average air-space of only 200 cubic feet per individual.

These lamentable conditions are notorious, so notorious that it is unnecessary to allege concrete examples, since every city furnishes a parallel. The physical deterioration which such conditions engender, as set forth in detail on a bed-rock of personal observation by the author, is but what one must expect. Moreover, the effects of unhygienic surroundings are enhanced by the carelessness and ignorance of mothers in respect of the alimentation and general care of

their offspring, resulting in a lamentable waste of infant life.

But the remedy! Obviously many of the conditions are the consequence of a social system which presses hardly on the wage-earning classes, and admit of but slow and uncertain amelioration. It is idle to promulgate laws and enforce measures for the prevention of overcrowding when every rookery razed to the ground intensifies the overcrowding in the neighbouring area, when rapacious and unscrupulous landlords are allowed to exact rents which, in amount, are inversely to the healthiness of the tenements.

Nevertheless, the author, who has gone very thoroughly into the subject, is enabled to make various practical suggestions to attenuate, if not to arrest, the progress of physical deterioration. The medical inspection and physical culture of school children, their better alimentation, the training of mothers, and the dissemination of a knowledge of elementary hygiene—these are measures which would certainly tend to prolong life and to raise the physical standard of the rising generation. Then, too, the alimentation of the adult population is a question of the greatest importance, both from physiological and economical points of view. If we can enlarge the dietetic horizon, if we can impart a knowledge of how to choose good food and how to cook it, we shall improve the physical condition and increase the comfort of the labourer's existence, and *pro tanto* lessen the temptation to alcoholic indulgence. We are, however, inclined to agree with the author that no great progress can be hoped for unless the matter be taken in hand from the earliest stage of child life, beginning by securing an adequate supply of clean milk for hand-fed infants. In towns, at any rate, it must be difficult to make up for shortcomings during infancy.

It is generally assumed that the tendency of the rural population to aggregate in towns is the result of a natural law which we are powerless to circumvent. But in reality it is nothing of the kind. Farm labourers leave the land because they are inadequately paid, and because of the wearisome monotony of their lives. They have to live in tumbledown cottages, when they are fortunate enough to find one in which to lay their heads, and their living is of the plainest. In old age they have only the workhouse to look forward to. Were there a system which would enable them to live in humble comfort, with a cottage and a garden of their own, if their employers only took the trouble to provide some sort of amusement for their scanty hours of leisure, no such wholesale emigration to the towns would occur. The system of "small holdings" is the one great inducement that can be offered to the farm labourer to remain in the country.

The author has discussed these points, and many others, in a magisterial manner, validating the statements by copious references to Blue Books and official reports. She establishes the existence of a wide-spread evil which threatens to sap the virility of the race, she studies its etiological factors, and she proposes the appropriate remedies. Truly the task is a heavy one, but it is not beyond the power of man to compass its ultimate achievement. The author has no panacea to offer us, but she makes it clear that we have the remedy in our own hands. It is a matter for individual effort in the main, laws being inoperative as against ignorance and indifference. We would appeal to all who are in earnest in this crusade against disease and racial decadence to read this eloquent indictment and to co-operate in the endeavour to inaugurate a happier future.

### SWAFFIELD ON LAPAROTOMY WOUNDS.(a)

In this most original little work Dr. Swaffield has collected the detailed methods adopted by some fifty of the leading Continental surgeons in closing the

(a) "The Closure of Laparotomy Wounds as Practised in Germany and Austria; including Detailed Methods and Views Communicated by over Fifty Leading Surgeons." Edited and translated by W. H. Swaffield, F.R.C.S., M.D. London: J. and A. Churchill. Pp. 72. 1904.

(n) "Physical Deterioration: its Causes and the Cure." By A. Watt Smith. London: John Murray. 1904. Price 6s.

incision made in abdominal cœliotomy. The different methods enumerated may be roughly divided into two groups:—Those in which a simple through-and-through suture is adopted, and those in which some method of suture in layers is adopted. We note that eleven alone of the fifty operators, whose views are given, are in favour of the former method, and that the majority of these, while they are all names of great weight, still represent the older, rather than the younger, school of surgeons. This coincides very closely with our own views on the subject, and we doubt that there is any future before the simpler method. To believe that a through-and-through suture can be made to bring about the same natural restitution of the parts that can be obtained by suture in layers is to us impossible. It may be, and we do not doubt it in this case, that an exceptional operator can obtain excellent results by the through-and-through suture, but even if he does do so, it is beside the question. What is required is the method which will give the best results in the hands of the ordinary surgeon, without demanding the expenditure of an undue amount of time. We are sorry that Howard Kelly's method of suturing has not found a place in this little *brochure*, as it has always appeared to us to be one of the best, if not the best of methods.

#### "THE EDINBURGH MEDICAL JOURNAL. (a)

The present volume (No. XV) of the *Edinburgh Medical Journal* maintains the high standard of excellence attained by its predecessors. The original contributions are twenty-seven in number, and the majority of them are of a practical character. We need do no more than quote some of the titles to show how helpful the literature of the volume must be to men in active practice. "Strangulated Hernia," "The Cardiac Muscle," "The Stools of Dysentery," "The Treatment of Bronchiectasis," "Cæsarean Section for Contracted Pelvis," "Fibrinous Bronchitis," and "The Neural Factor in Heart Disease." Besides all this the volume contains a series of articles on "The Insanities and Criminal Responsibility," by Sir John Batty Tuke, and Mr. C. R. A. Howden, Advocate, which is of permanent value, and giving, as it does, the ripe experience of such a distinguished alienist as Sir John Batty Tuke, cannot be overlooked by those specially concerned with the study of mental diseases and social reforms. Under the heading "Recent Advances in Medical Science," the different provinces of medical science are passed under review in each monthly number: Medicine, surgery, obstetrics, gynaecology, therapeutics, pathology, diseases of the ear, nose and throat, and public health; this last section is edited by Dr. J. Buchanan Young, and is one of the most interesting summaries of the progress of preventive medicine with which we are acquainted. We have occupied an unusual amount of space in this notice, but we feel that we could not otherwise have given our readers a true picture of the wealth of information the journal contains. Well-selected matter of a practical character, conveniently arranged and excellently designed to meet the requirements of the student and the busy practitioner. The printing, illustrations, and paper are all good, and the volume reflects credit on all concerned in its publication.

#### BLAND-SUTTON ON TUMOURS. (b)

In the third edition of this admirable work the author has made some important alterations and additions. The term "epithelioma" has been abandoned and replaced by the phrase "squamous-celled cancer." We regard this change as a good one, on the ground that it places the nomenclature and classification of these tumours on a more satisfactory basis. Another marked step in advance is the separation of ovarian fibroids and myelomata from the sarcoma group, and

their recognition as separate entities. We think it probable that in a later edition the author will deal similarly with "deciduoma malignum," which he provisionally places, in this edition, among the sarcomata. We should have liked to see a fuller account of these tumours, with some illustrations; but no doubt the reason of the brief description given is to be found in the uncertainty which the author regards as still prevailing as to the true nature of "deciduoma." As a matter of fact, a very important contribution to the subject was made soon after this volume was published. Mr. Bland-Sutton has amplified the section on uterine fibroids, and has done excellent service to the sufferers from these tumours by demonstrating the modes in which fibroids imperil life. In the second edition the section on echinococcus colonies was omitted, but, yielding to representations from readers who regretted the omission, the section has been restored with additions, which render it a valuable feature of the book.

It is not necessary to enter upon a detailed criticism of a book which is so well known, and which may be ranked as a classic. This third edition is a worthy successor to the previous ones, and fully maintains the author's high reputation as an authority on the subject. To any of our readers who may not previously have made the acquaintance of "Tumours" we cordially recommend it as a book from which they will derive a vast amount both of pleasure and of profit.

#### RIDDELL'S MANUAL OF AMBULANCE. (a)

In revising this well-known ambulance hand-book the author has taken the opportunity of extending its already recognised utility by making certain material additions to it. We would particularly note the excellent new series of full-page illustrations of stretcher drill which are extremely well reproduced. He has also added a chapter on electrical accidents, while that on the organisation of ambulance classes has been considerably amplified, and, we think, improved. The chapter on anatomy and physiology contains some very good plates, while the explanatory text treats the subject in a very lucid manner. In dealing with ambulance transport and stretcher drill, the author gives what is perhaps one of the best accounts of these subjects which can be obtained. It is not only clear and to the point, but it is so well illustrated that the student should have no difficulty in mastering the details of this very important branch of ambulance work.

It is a pity that the author should have inserted a chapter on the after-treatment of ambulance cases. Surely the principles of first aid do not come into operation once that aid has been given. Therefore we think more harm than good is likely to ensue from the insertion of temperature charts and figures of Leiter's tubes. In a subsequent edition we should certainly advise the withdrawal of this chapter altogether. Apart from this, we can thoroughly endorse all the good things that have been said regarding previous editions of this work. This, the latest, edition will be found not only an admirable guide for students, but a useful work of reference for teachers.

#### GOWERS' MEDICAL OPHTHALMOSCOPY. (b)

It is now twenty-five years since this important work was first issued. Since then the science of ophthalmoscopy has undergone many changes, and improvements in the instruments used in its study, together with advance of knowledge of the morbid

(a) "The Edinburgh Medical Journal." Edited by G. A. Gibson, M.D., F.R.C.P. Ed., and Alexis Thomson, M.D., F.R.C.S. Ed. New Series. Vol. XV. Edinburgh and London: Young J. Pentland, 1904.  
(b) "Tumours, Innocent and Malignant." By J. Bland-Sutton, F.R.C.S. Third edition, with 312 illustrations. 556 pp. Cassell and Co., Ltd. 1903.

(a) "A Manual of Ambulance." By J. Scott Riddell, C.M., M.B., M.A., Senior Surgeon and Lecturer on Clinical Surgery, Aberdeen Royal Infirmary, &c. Fifth Edition. Revised and Enlarged. 4s. London: Chas. Griffin and Co., Ltd. 1904.

(b) "A Manual and Atlas of Medical Ophthalmoscopy." By S. Wm. B. Gowers, M.D., F.R.C.P., F.R.S., Hon. Fellow, Royal College of Physicians of Ireland, Consulting Physician to University College Hospital, &c. Fourth Edition. Edited by the Author and Marcus Gunn, M.B., F.R.C.S., Surgeon to the Royal London Ophthalmic Hospital, Ophthalmic Surgeon to the National Hospital for the Paralysed and Epileptic, 14a, net. London: J. and A. Churchill, 1904.

conditions observed, have made it incumbent upon the author to call in the aid of an ophthalmic surgeon, so as to bring the work thoroughly up to date. He has been fortunate in obtaining the services of Mr. Marcus Gunn, "whose experience," as the author aptly remarks, "has been wide in range and wisely used."

The general plan of the work is so well known that we need hardly do more than refer to it here. In the first portion retinal and optic nerve changes are dealt with *seriatim*, the condition of optic neuritis being treated of in a particularly exhaustive and complete manner. The second portion, however, is the one which is most useful to the physician, as in it the ophthalmoscopic changes occurring in special diseases are fully gone into. In speaking of tuberculous meningitis, Gowers points out that tubercles of the choroid are less frequently found than in general tuberculosis without meningitis. He gives 65 as the percentage of cases of locomotor ataxia associated with optic atrophy, and incidentally mentions that "tabes must be ascribed to the action on the nervous system of a post-syphilitic toxin."

The appendix consists of a series of valuable autotypes which have been somewhat improved in this edition. They are certainly beautiful reproductions, and illustrate in a singularly clear way the various morbid conditions met with in ophthalmoscopic examination. While they can never replace practical work, these plates are of the greatest possible service for reference by those who have difficulty in making a diagram of the ophthalmoscopic appearances presented on the examination of any particular case.

There is no work in any language to compare with the one under review. It has hitherto been regarded as a standard work of reference on medical ophthalmology. This new edition is certain to increase its popularity not only in this country, but also abroad, and it must for many years to come remain the authoritative expression of all that is best in British and foreign teaching on the subject.

## Medical News.

### The Plague.

THE following telegram from Sir Cavendish Boyle, Governor of Mauritius, has been received at the Colonial Office:—For week ending August 25th, ten cases of plague, five fatal.

### Allen Lunatics.

A RETURN was recently presented at the Lancashire Asylums Board meeting at Preston showing the number and nationality of alien patients in the asylums. The total numbers were 88 males and 46 females. Of these six were Americans, two Arabs, two Austrians, one Belgian, one British St. Vincent, one Dane, two Dutchmen, five Frenchmen, 28 Germans, 11 German Jews, one German Pole, one Greek, 12 Italians, five Norwegians, one North American negro, seven Poles, one Portuguese, two Roumanians, seven Russians, four Russian Jews, one Russian Pole, one South African, two South Americans, two Spaniards, 13 Swedes, one Morocco Jew, and 14 whose nationalities were unknown.

### Röntgen Rays for the Russian Army.

It is stated that the Russian hospital which is being sent to the seat of War by the citizens of Moscow will have a first-rate Röntgen ray outfit. From the report, it would almost seem as if the advantages of that method of diagnosis had not yet been widely adopted by the medical profession in Moscow.

### Bequests to Medical Charities.

Under the will of Mrs. Jane Bowron, of Hove, who died on July 17th last, the sum of £2,000 is bequeathed to the Sussex County Hospital; £1,500 to Lady Kinnaird Memorial Hospital for Women, at Benares; £1,500 to the Agra Medical Missionary Training Institute, affiliated to the Medical Missionary Society, at Morning-side Park, Edinburgh; and £1,000 to the Brighton, Hove, and Preston Medical Dispensary.

## PASS LISTS. University of London.

At the general intermediate examination in medicine for internal students held in July, the following candidates were successful:—

Ella Mabel Barker, Charles Anthony Basker, Harold Garfield Bennett, Sylvia Rose M. Blackstone, Mary Alice Blair, Harry Blakeway, Gerald Tyler Burke, Thomas W. Higgins Burne, Angel Camacho, Thomas E. Ashdown Carr, Henry Joseph Cates, Herbert Stanley Chate, Bertram Walter Cherrett, Arthur Beauchamp Coomber, Herbert Rees Davies, Kenelm Hutchinson Digby, Reginald Lionel Ernest Downer, Sheldon Francis Dudley, Robert Cecil Turle Evans, Marmaduke Fawkes, Allan Bains Fearnley, William Stephen Fenwick, Janet Marcia Fische, Alexander Fleming, Sidney Frank Fouracre, Ernest William Giesen, Sidney Wilfred Grimwade, Edith Mary Guest, John Hadwen, Eric Henry Rhys Harries, Henry John Henderson, Tom Shadick Higgins, John Ernest Hodson, Hendrik Houwink, Douglas Walter Hume, Mary Sophia Jevons, Elizabeth Herdman Lepper, Clifford Antony L. Mayer, Marian Mayfield, Minnie Merrifield, Ethel Mary Morgan, William Poole Henley Munden, Frederic Miller Nield, Henry John Nightingale, Humphrey Nockolds, Edgar Lionel Robert Norton, Charles Aubrey Pannett, Walter Patey, Catherine Payne, August Frederick Perl, Arthur John Scott Pinchin, Edward John Price, Mona Dew Roberts, Richard Cadwaladr Roberts, Henry Charles Samuels, William Octavius Sankey, Marie Simpson, Eliza Macdonald Smith, Henry Joste Smith, George French Stebbing, Alfred K. B. R. W. Taylor, Douglas Compton Taylor, Alfred Charles Foster Turner, James Richard Henry Turton, Winifred Emmeline Watts, Harry Gordon Webb, Leonard Henry Wootton, and Carl Ernst Zundel.

At the intermediate examination in medicine for external students held in July, the following candidates were successful:—

Laurence Ball, Sydney Herbert Booth, Ernest Frederick Finch, Robert Applegarth Hendry, James Ernest Middlemiss, Edward Selby Phipson, Harry Richardson Rawlings, Arthur Toulmin, Arthur Henry Turner, and Joseph W. James Willcox.

## University of Oxford

THE following degrees in medicine were conferred during the summer term:—

*Doctors of Medicine.*—Thomas E. C. Cole, Edgar W. Willett, William A. P. Waters, Gustav J. Schorstein, and Arthur E. Boycott and John D. Rolleston.

*Bachelors of Medicine and Surgery.*—W. B. Billinghurst, A. C. Inman, A. F. Hertz, A. E. A. Loosely, J. H. Thomas, R. D. MacGregor, and P. A. Mansfield.

Degree days are announced as follows for the coming term:—Thursday, October 20th; Thursday, November 10th; and Saturday, December 17th. Examinations for scholarships offered in natural science will be held on December 6th, at Balliol College, Christ Church, and Trinity College; on December 13th, at Lincoln and Magdalen Colleges; on January 17th, 1905, at Jesus College; and on March 14th, 1905, at Keble College.

## Society of Apothecaries of London.

At the examinations held in August, the following candidates passed in the subjects indicated:—

*Surgery.*—R. H. Cooper (Section II.), A. W. S. De Vine (Sections I. and II.), E. F. W. Hoare (Sections I. and II.), A. C. Story (Sections I. and II.), and R. H. Terry (Section I.).

*Medicine.*—G. B. Messenger (Section I.), C. S. Scott (Section II.), I. C. Thorburn (Sections I. and II.), A. B. S. Todd (Section II.), and S. H. R. Welch (Sections I. and II.).

*Forensic Medicine.*—C. W. S. Boggs, E. F. W. Hoare, J. E. Jones, I. C. Thorburn, and H. M. Waller.

*Midwifery.*—W. G. H. Cable, and W. R. Elliott. The diploma of the Society was granted to the following candidates entitling them to practise medicine, surgery, and midwifery:—R. H. Cooper, A. C. Story, A. B. S. Todd, and S. H. R. Welch.

## 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.

**M. D. CANTAB.**—The only way of protecting yourself against such an unpleasant contingency in future is to refuse to give evidence before being paid your fee. It is open to you to refuse this in the witness-box *before* you are sworn.

### THE PRESERVATION OF RUBBER CATHETERS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

**SIR.**—Can any of your readers tell me how to keep red rubber (flexible) catheters from becoming "sticky." I find if they have been in constant use for about a month they swell and lose their gloss I have tried boiling, etc., but all to no use.

Yours truly, F. WINDER.

A correspondent writes:

**SIR.**—Perhaps some of your readers can give me some advice in the following case: An officer, age 45, still serving in militia, of good general health, applies for insurance. He has served through various arduous campaigns but escaped serious illness or injury except on one occasion. He was then shot through the thigh with a low velocity bullet, and had a septic wound that caused extensive damage to the leg. He lost two stones in weight, and which he has not regained after ten years interval. He is organically sound, so far as one can tell, except that the specific gravity of urine is 1006, but not excessive in quantity. This life is clearly not first-rate. Is it insurable?

Yours faithfully, C. F.

### THE DIMINISHING BIRTH-RATE.

Vide THE MEDICAL PRESS and the Bishop of Ripon.

I thank the foresight, commonsense,  
Which on my birth have smiled  
And made me in this crowded world  
An only healthy child.

The Psalmist, had he lived to-day  
In truth would not be able  
To call him blessed who has swarms  
Of children round his table.

My bishop and my doctor both  
Quote dimly statistics,  
The Politician, on his side  
Quotes overcrowded districts.

My mother knows were she to aid  
A still decreasing birth-rate  
A fight would come to keep paid up  
The gas bill and the poor rate.

I thank (as I remarked before),  
Although I'm rather lonely  
That commonsense which keeps me still,  
My parents "one and only."—ONLOOKER.

**SYLVANUS** writes that he has received a letter from a consultant physician under the following circumstances. A patient came under his care with secondary syphilis. It appears that this patient was sent to the consultant by a mutual friend who paid the first fee, but was not prepared to pay for a course of treatment. The patient then came under our correspondent's care. A few days later a note came from the consultant recommending the administration of iodide of potassium, together with mercury, on account of the high temperature, and saying how the case had come under his notice. Our correspondent asks what he should do.

[In our opinion, as the consultant has gone out of his way to prevent any misunderstanding, it would be only courteous of our correspondent to write a detailed answer, and if he does not agree with the suggested plan of treatment to state briefly his views on the point.—Ed. M. P. & C.]

### A HOSPITAL CURIOSITY.

When pulling down the old Waterloo Hospital for Children for the new building, a discovery was made under the foundation stone of a glass tablet, with the names of the founders and date, &c., encrusted therein. Also a small copper coin, and copy of the Annual Report of the Hospital for the year 1822, contained in a bottle, and all in an excellent state of preservation. Among the Patrons and Vice Patrons of the Institution were the following interesting names:—The Duchesses of Kent, Northumberland, and Princess Augusta,

the Dukes of York, Sussex, Grafton, Rutland, Beaufort, &c., the Rt. Hon. Robt. Peel, Sir Humphry Davy, and other well known People.

## Vacancies.

**Bradford Poor-Law Union.**—Medical Officer of Sanatorium.—Resident Medical Officer. Salary £100 per annum, with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, 22 Manor Row, Bradford.

**Cardiff Union.**—Assistant Medical Officer. Salary £120 per annum, with rations, apartments, attendance, and washing. Applications to Arthur J. Harris, Clerk, Union Offices, Queen's Chambers, Cardiff.

**The Zanzibar Government.**—Medical Officer for the Island of Pemba. Salary £280 per annum. (Applications to W. S. W. N., care of Streets, 30 Cornhill, E.C.)

**Down District Lunatic Asylum, Downpatrick.**—Junior Male Assistant Medical Officer. Salary £100 per annum, with furnished apartments, board, washing, fuel, light, and attendance. Applications to the Resident Medical Superintendent.

**Wandsworth Union.**—District Medical Officer. Salary £100 per annum. Applications to F. W. Piper, Clerk, Union Offices, St. John's Hill, Wandsworth.

**Great Yarmouth Hospital.**—House Surgeon. Salary £90 per annum, with board, lodging, and washing. Applications to Richard F. F. Ferrier, Hon. Secretary, 33 Hall Plain, Great Yarmouth.

**Hamstead General Hospital.**—Resident Medical Officer. Salary £120 per annum, with rooms, coals, and gas. Applications to George Watts, Secretary.

**Boothle General Hospital, Liverpool.**—Junior Resident. Salary £80 per annum, with board and laundry. Applications to the Secretary, Boothle Hospital, Derby Road, Boothle.

**Ballinasloe District Asylum.**—Second Assistant Medical Officer. Salary £140 per annum, with cash allowance of £25 in lieu of rations, &c. Immediate application to the Resident Medical Superintendent, James St. L. Kirwan. (See Advt.)

**Open-air Sanatorium for Consumptives, Limley Stoke, near Bath.**—Resident Medical Officer. Salary £200 per annum. Applications to "Chairman," N.A.P.C., 84 Park Street, Bristol.

## Appointments.

**GREENE, ARNOLD J.,** M.B.O.S.Eng., L.R.C.P.Lond., Honorary Assistant Medical Officer to the Royal Albert Edward Infirmary, Wigan.

**JACKSON, F. W.,** L.R.C.P.Lond., M.B.C.S., Certifying Surgeon under the Factory Act for the Market Basen District of the county of Lincoln.

## Births.

**BISSHOPP.**—On August 26th, at Parham House, Tunbridge Wells, the wife of Francis E. B. Bishopp, M.A., M.D.Cantab., M.R.C.P. Lond., of a daughter.

**O'DWYER.**—On August 17th, at Sunnyside, Tipperary, the wife of Dr. Joseph O'Dwyer, of a son.

**RADFORD.**—On August 3rd, at Nairobi, East Africa Protectorate, the wife of William J. Radford, F.R.C.S., of a son.

**SWAIN.**—On August 25th, at 4 Victoria Square, Clifton, Bristol, the wife of James Swain, M.B., M.D.Lond., F.R.C.S., of a daughter.

## Marriages.

**BRONHALL—DRAKE.**—On August 24th, at St. Peter's Church, Mount-sorrel, Loughborough, Ernest Bronhall, M.B.O.S.Eng., L.R.C.P. Lond., Raw'entall, to Beatrice, only daughter of the late Rev. Thomas Drake, M.A., vicar of St. Peter's, Mountsorrel.

**DANIEL—WELSH.**—On August 23rd, at All Saints', Ennismore Gardens, S.W., Augusta Moore Daniel, son of the late Edward M. Daniel L.R.C.S. (Ireland), and of Mrs. Daniel, Saxifield, Scarborough, to Margery Katherine, elder daughter of William Welsh, of Bifrons, Fleet, Hants.

**EDMONDS—FLOYD.**—On August 27th, at the Superintendent Registrar's Office, Westminster, Percy J. Edmonds, M.B., B.Sc., M.R.C.S., of 5 Great Marlborough Street, London, W., to Clara E. Edmonds, third daughter of the late William Floyd, of Weybridge.

**EWART—BERNEY.**—On August 24th, at St. Thomas's Church of England, Edinburgh, E. W. T. Ewart, M.B., eldest son of Lieut-Colonel Ewart, of Allerahaw, Lanarkshire, to Catherine Ann, youngest daughter of Sir Henry H. Berney, Bart., of Barton Bendish, Norfolk.

**GRIFFITH—ROBERTS.**—On August 23rd, at Llanystumdwy Church, Cardarvonshire, Idwal Griffith, Moria f Nevin, younger son of Samuel Griffith, M.D., J.P., of Portmadoc, to Lilian Gaynor, elder daughter of John Roberts, M.D., Talarvon, Cricieth.

## Deaths.

**CLARKE.**—On August 14th, at Villa Choisy, Interlaken, Switzerland, Thomas Clarke, M.D., in his 78th year.

**WHIDBORNE.**—On August 24th, at Warwick House, St David's, Exeter, Catherine S. W. Whidborne, widow of George Ferris Whidborne, M.D., ag d 81.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, SEPTEMBER 7, 1904. No. 10.

## Original Communications.

### THE PREVENTIVE TREATMENT OF SCARLET FEVER

BY ISOLATION (AGGREGATION) HOSPITALS.

By HUBERT E. J. BISS, M.A., M.D. Cantab., D.P.H.,  
Eastbourne;  
Late Assistant Medical Officer, Metropolitan Asylums Board.

#### PART II.

IN the last issue of THE MEDICAL PRESS AND CIRCULAR I spoke of the difficulty attending the diagnosis of the mild varieties of scarlet fever, and of how this fact seemed to me to be fatal to any consistent system for extirpating, or even largely reducing, the incidence of the disease by isolation. These mild cases occur even in the most severe epidemics, but with the change of form that scarlet fever has undergone during the last twenty-five or thirty years, they are much more frequently met with than formerly. Indeed, the whole character of scarlet fever to-day is so benign that it is a matter for consideration whether the disease is of sufficient moment to the community to warrant large expenditure of money to combat it. As I said earlier in this paper, scarlet fever was a dreaded, and justly dreaded, foe during the middle of the nineteenth century. Its reign was capricious, autocratic, and arbitrary, and its death-rate appalling. Independent of any human effort, however, it gradually changed its form, and before the aggregation hospital had been established as a recognised institution, it had become, like the scarlet fever of Sydenham's day, a disease in name only. There are, of course, still a proportion of severe and fatal cases, but the death-rate is now so low, some 3 per cent. on an average, that the importance of scarlet fever as an epidemic disease is greatly discounted. Measles and whooping-cough are far more dangerous and fatal, but the general opinion is that isolation is not worth trying as a means of controlling either of them; and with that opinion most people who are acquainted with these diseases, and have thought over the subject, will be disposed to agree. Supposing it be admitted that by the aggregation hospital system a certain proportion of attacks of scarlet fever are prevented, the question has to be faced as to whether it is a good investment of the money available for preventive medicine, to spend the enormous sums in sparing a few persons the trifling discomfort entailed by the disease in its modern form. For it must be remembered that by keeping up the present contributions a hundred and one useful sanitary measures are handicapped or rendered impracticable. The matter from this point of view has a commercial aspect that deserves careful attention. If the investment is justifiable, let it be retained; if it is not returning its value in security and relief to the population, let it be exchanged for some more profitable one. This scarlet fever expenditure is no small matter. In London three-fifths of the fever patients of the Metropolitan

Asylums Board are admitted for scarlet fever, and one may therefore reckon three-fifths of the Board's expenditure as incurred on account of that disease. Taking the year 1902 one finds that three-fifths of the fever hospital expenses amounted to no less than £222,000, and three-fifths of the fever ambulance service to £21,000. Without reckoning the proportionate part of the central office expenses, one arrives at the conclusion that scarlet fever aggregation costs London some quarter of a million pounds annually—the amount produced by a penny-halfpenny rate. If one turns to capital account and takes three-fifths of the amount sunk in fever hospital construction and equipment, one finds £1,333,000 incurred under this head, and £36,000 for capital expenditure on ambulance stations. In these figures I have not included the cost of Gore Farm Upper Hospital, which is frequently used for scarlet fever, nor the amount proposed to be spent on the new hospital of 800 beds at Carshalton. Here, again, one ought to add three-fifths of the capital expenditure on the central office, but leaving these items and interest on borrowed money out of account, the bill amounts to practically one and a half million pounds. It is difficult to escape from the reflection that a disease which causes only some five or six hundred deaths a year in London—deaths that would by no means be averted were the hospital service suspended to-morrow—is hardly worth so much expense. Without advocating unreservedly the use of these hospitals for the treatment of tuberculosis, I cannot but think that far greater relief would be accorded to suffering humanity if they were so employed. At the moment three-quarters at least of their accommodation is devoted to sustenance of healthy, able-bodied persons whose only sin against their fellows lies in the possession of a little shaggy skin on their hands and feet. If they were all let loose to-morrow there would probably be no rise in the scarlet fever notifications; the experiment has been tried elsewhere, and no adverse results followed.

When speaking of the records of epidemics of scarlet fever in the past, I referred to the constant confusion of that disease with other throat affections, especially diphtheria, and I ventured to express my impression that the two diseases often prevailed side by side. Nowadays, when we have a standard of reference for the diagnosis of that which we call diphtheria, we find that the old clinical distinctions are not of the value that they were once thought to be. If "diphtheria" gains in distinctiveness by the possession of its own bacillus, its borders are broadened to include a number of cases that have only that bacillus as their credential to the term. Nor is this all. Many a case that formerly gave the diagnostician no hesitation, no *arrière-pensée* of any kind, is now looked upon with a suspicion which can be dispelled only by the bacteriologist. A proportion of scarlet fever cases, varying according to circumstances, always contain Klebs-Löffler bacilli, in combination with other organisms, in the throat-exudation. Now, although these cases may present clinically no symptoms of diphtheria, they are potent to infect with the diphtheria organism, not only their neighbours in a ward or house, but even themselves at a later (convalescent) stage of their own illness. Consequently the scarlet fever wards of a hospital are seldom long

without diphtheria breaking out in them, and it is difficult to see how this can be avoided. Were all cases on admission subjected to bacteriological examination, and detained in wards separate from the other scarlet fever patients during their residence in hospital, it might be that post-scarlatinal diphtheria would become less frequent. But the administrative difficulties of arranging for such isolation are great, and till they are overcome it must be anticipated that scarlet fever patients will suffer from the evils of indiscriminate aggregation, and diphtheria be a common-place incident among scarlet fever convalescents. Aggregation of human beings is a non-rational device and always finds its reflection in disease outbreaks; this is true of every form of aggregation that has ever been brought about—camps, towns, schools, prisons, and what-not. Hospitals have shared this tendency in the past, and they continue to exhibit it even under modern regulation. Even in well-planned buildings in which every precaution that sanitary science can suggest is adopted, the mere accumulation of human beings under one roof has been shown to be essentially vicious. Thus, Dr. Sykes in his Milroy Lectures to the College of Physicians in 1901, speaking of the Peabody and Model buildings in St. Giles's, pointed out that whereas in these dwellings (which contain a good class of tenant, well supervised) the general and infant mortality is much below that of London generally, nevertheless the death-rate from certain infectious diseases is in excess—a result he attributed to nothing but the aggregation of numbers of people in a limited space.

Without amounting to alarming proportions post-scarlatinal diphtheria is still common enough to give cause for serious misgiving, though, happily, its mortality is enormously reduced by early diagnosis and serum treatment from what it was in pre-antitoxin days. If one takes the records of the last five-year period (1898-1902) of the Metropolitan Asylums Board Hospitals, one finds that 2,562 patients admitted for scarlet fever contracted diphtheria in hospital, and of these 105 died. Nor was this result accomplished by any particular epidemic; it was due to the day-in and day-out sequence of little groups of infections in different hospitals and different wards. The regularity of the appearance of diphtheria may to a certain extent be gauged by the yearly figures. Thus:

Year.	No. of Cases.	Deaths.	Mortality p.c.
1898	661	24	3'6
1899	692	25	3'6
1900	405	12	2'96
1901	380	23	6'05
1902	424	21	4'95

Here it will be seen that except for slight fluctuations the average of post-scarlatinal diphtheria was well maintained in each year, and it seems likely to continue to be so under prevailing conditions. Thinking that diphtheria infection of scarlet fever patients was perhaps the result of receiving patients suffering from the two diseases into the same hospitals, the managers of the Metropolitan Asylums Board arranged in 1901 to use for their separate treatment two neighbouring hospitals—the Grove and the Fountain—the former being reserved for diphtheria, the latter for scarlet fever. One year's experience sufficed to show that this method was not of any avail for the purpose, and the old arrangement was consequently reverted to. Not only is diphtheria a constant occurrence in scarlet fever wards, but scarlet fever is equally a feature of diphtheria wards, and though figures under this head are not available for citation, I should give it as my general impression that post-diphtheritic scarlet fever is about as common as post-scarlatinal diphtheria. It may safely be said, at any rate, that scarlet fever is a very usual feature of diphtheria wards. But scarlet fever in diphtheria wards and diphtheria in scarlet fever wards are not the only banes of the fever medical officer's life, for measles, whooping-cough, rōtheln, and chicken-pox are daily events, and frequently two or more of these maladies occur synchronously. The number of beds available for hospital purposes is practically always gravely curtailed by various wards being placed

*hors de combat* from outbreaks of one or other of these diseases, and it is idle to say that such occurrences are not a serious blot on the efficiency of the institutions, not to mention the opprobrium they bring on the administration. A fever hospital has been wittily described as "a place where you go in with one disease and catch all the others." Like most epigrammatic sayings, this is more *ben trovato* than exact, but it contains a germ of truth. Under present circumstances, and without enormously increasing the expenditure on these hospitals, I fail to see how things are to be otherwise.

Another danger of the fever hospital—likewise to a great extent unavoidable—is that of wrong primary diagnosis of the disease from which the patient is suffering. If protection is to be afforded by the hospital, prompt and early removal of the patient is essential to success. Medicine, however, does not lend sufficient aid to its followers to ensure this being always done, and one is not surprised that a large number of patients are annually sent in certified to be suffering from scarlet fever who, in fact, are not. During the same five-year period (1898-1902) that I have before referred to, I find that into the Metropolitan Asylums Board Hospital, 3,118 persons were admitted for scarlet fever who were the subject of other maladies. The proportion they bore to the total admissions was as follows:—1898, 4'7 per cent.; 1899, 3'9 per cent.; 1900, 5'8 per cent.; 1901, 5'9 per cent.; 1902, 4'8 per cent. It is one thing to say that a person has scarlet fever, but quite another thing to say that he certainly has not, so that in practice the usual course is to retain patients so certified till the diagnosis can be confirmed or refuted. Thus many persons are detained in hospital for a fortnight or three weeks, and as isolation accommodation is not always available, a certain number of them disprove the original diagnosis by catching scarlet fever while under observation. For a reduction of these mistaken primary diagnoses one cannot look. If scarlet fever is to be dealt with vigorously under any isolation plan, it will become necessary to certify and remove on suspicion a vastly larger proportion of doubtful cases than at present. Little as one may like the prospect, I can see no alternative if this preventive measure is to be thoroughly tried and pushed to its logical conclusion.

But even if all these difficulties and disabilities could be removed, there remains one further circumstance which, like the fly in the 'pothecary's ointment, is like to spoil the whole of the roseate scheme. This mild disease has proved hitherto as little susceptible to the wooings of the clinician as to the big guns of the municipal sanitary department. It is neither charmed by the one nor frightened by the other. Like a coy girl, scarlet fever grudgingly reveals its secrets to those who pay it attention, and only those whose information is derived solely from text-books can think they have any knowledge of the vagaries of the disease. It must have been supposed by those responsible for inaugurating the aggregation hospital that scarlet fever was an acute infectious disease that ran a fairly definite course, and left the patient at the end of a fixed period free to mingle with his fellow-men without endangering their health by his proximity. If there is one thing that the aggregation hospital has done, it has been to demonstrate its own ineptitude as a safeguard against scarlatinal infection. Clinical knowledge of scarlet fever has been wrung little by little from studying the disease at close quarters under hospital conditions, and, though it be not yet generally admitted, there can now, I think, be no reasonable doubt that the lengthened infectivity of scarlet fever is due to certain local lesions produced by the disease tending to run a subacute or chronic course in certain constitutions. The chief of the lesions are inflammations affecting the pharynx, nasopharynx, ear and nose. The class of case in which these events occur must surely have been overlooked by the founders of the hospital system, for it invalidates and renders nugatory no inconsiderable proportion of the benefit that might otherwise accrue to the community from the preventive influence of the system.

Inflammatory lesions of the pharynx in scarlet fever are almost invariably characterised by a persistence that contrasts markedly with the course of like lesions in diphtheria. A few days after even a severe attack of diphtheria will generally find a patient's throat-tissues pale, not swollen, clean and white. With scarlet fever, even if ulceration does not occur, nearly always one finds the throat reddened for a long time, the tissues more or less œdematous, the submaxillary lymph glands hard and knotty. A similar intensity marks inflammations of the naso-pharynx and nasal tissues when these are affected, and the otitis media of the disease is usually a persistent one. Moreover, for a long time after apparent convalescence, any slight chill or similar adverse circumstance is apt to convert these subacute conditions into active ones, and recrudescence of the pharyngitis, rhinitis, or otitis media results. Especially in children with hypertrophy of the adenoid tissues of the naso-pharynx and obstruction to the free passage of air through the nose, does this happen. These inflammatory lesions of the upper air passages may directly follow the primary attacks of scarlet fever, or they may remain quiescent for a long time. Frequently they subside; not infrequently they persist. The subjects of these manifestations suffer at intervals from tonsillitis or pharyngitis; submaxillary lymph-adenitis, leading perhaps to abscess; chronic otitis media, with, sometimes, infection of the cells of the temporal bone, lateral sinus or brain; chronic rhinitis with nasal discharge. The more serious of these affections naturally detain the patient in hospital till death or cure release him, but a quiescent otitis media or rhinitis, offering as they both do no external sign of their presence, allow many a patient to be sent home in a potentially infectious state. It is impossible to attribute blame to the medical officer. So common are these chronic lesions that if one waited till all sign of inflammatory trouble had disappeared from throat, nose, and ear, a good half of the patients would be detained for many months. Practically this is impossible, and the rule is to send home those cases which do not exhibit, after a period of weeks, any sign of active disease. The general result is that the conditions gradually disappear, but unfortunately this is not always so. Some tangible or intangible influence resuscitates the lurking poison, and discharge from the nose or ear appears from the revived inflammation; the child is then at least as infectious as he was on the day he came to hospital. Every fever hospital has its "return" cases, as they are called, no matter how careful its administration. No one can tell which of a hundred discharged cases will prove to be infectious afterwards, but one knows that three, four, or five of them will infect their relations or playfellows, sooner or later. In fact, as a medium for disseminating scarlet fever, it is difficult to conceive of anything more appropriate than a healthy youngster, who has no worse trouble than a running nose, attending school, gambolling with his mates, and daubing their toys with the secretions of his infected nasal mucous membranes. Mere retention of these cases with chronic lesions of the upper air passages in hospital does not suffice to emasculate the infection; one patient of the Metropolitan Asylums Board was kept for eight months on account of a nasal discharge, but returning home, apparently cured, he conveyed scarlet fever to his brothers and sisters. Various devices—none very promising, perhaps—have been resorted to to obviate the slur which the return case is supposed to cast on hospital administration, but so far none have achieved even a modicum of success. The liability to discharge cases that prove afterwards to be infectious lies in the facts that scarlet fever is a disease with subacute and chronic tendencies; that we have but poor means of diagnosing in which case these tendencies will be displayed; and that the hospital system is impotent to provide means to control them. There is one minor reform that might accomplish some good: I mean abandonment of the traditional practice of giving children a hot bath immediately before sending them out of the hospital gates. Any measure better calculated to stir into activity the smouldering inflammations in the upper respiratory passage it is hard to imagine.

But this really is a side issue; the whole question is far deeper and broader and more far-reaching. The point is that the hospital system and clinical knowledge and methods are inadequate to cope with the demands made on their resources by scarlet fever, and that while return cases continue in fair abundance one cannot regard the hospital—apart from every other objection—as fulfilling a function of much service to the community. When we add to this disability the positive evils resulting from aggregation, the lack of any diminution in the mortality and prevalence of the disease, the mistakes—unavoidable mistakes, if isolation is to continue—in certification, and the inability of medical science to distinguish mild cases of scarlet fever, and to sift single infections from complicated ones, we are driven to the conclusion that the present system is but ill-adapted to the end for which it was designed. With these grave faults and shortcomings, is it worth while continuing the enormous expenditure on our aggregation hospitals? Is it worth while, in any case, when scarlet fever is now so benign in its incidence that 80 per cent. of its victims are but little more than out of sorts for a few days? These questions deserve, I think, serious consideration, and if they are kept at the level of scientific reasoning that their interest and importance entitle them to, they are ripe for free discussion among sanitarians. I trust they may be preserved from the hurly-burly of municipal politics with which they have no primary concern, and that a full and authoritative inquiry under medical auspices may be instituted to resolve them.

### THE EARLY MANIFESTATIONS OF INSULAR SCLEROSIS,

WITH A TABLE SHOWING THE MODES OF ONSET IN FIFTY CASES, TAKEN FROM NOTES MADE AT THE NATIONAL HOSPITAL, IN QUEEN SQUARE, BY THE KIND PERMISSION OF THE MEDICAL STAFF.

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IN the seventh of Charcot's classical lectures delivered at La Salpêtrière in 1858, portraying the disease, justly designated disseminated or multilocular sclerosis, he maintained that "nothing is simpler than to diagnose the affection in question by the bedside of the patient, at least when it has reached its typical period of perfect development."

The paragraph read according to its literal construction is probably not far from the truth. The clinical tableau so accurately sketched by the distinguished French neurologist remains after an interval of thirty-six years a faithful representation of what is known as the classical type. Nor would it be easy, in confrontation of such complete evolution of the symptomatology as he described, to mistake its significance. It did not, however, escape Charcot's notice that the disease may be encountered under a variety of masks—in all sorts of disguises—and that in these aberrant or imperfect forms the recognition of the primary indicia is by no means a simple proceeding. That these atypical varieties undoubtedly exist, and are not of very rare occurrence, constituting the class known as *formes frustes*, is now commonly admitted. Such cases not infrequently run a protracted course of years from start to finish, presenting few of the salient features of the typical disease until an advanced stage has been reached, and sometimes (though more rarely) none that can be called absolutely characteristic. The importance of recognising the manifestations of these irregular types has been strongly insisted on by Dr. Buzzard, who, from long experience and careful study of the subject, has made it in a peculiar sense his own. It is impossible to question the accuracy of his assertion, "that of all organic diseases of the nervous system, disseminated sclerosis is that which is commonly mistaken for hysteria."

The polymorphic nature of the malady, its variable periods of remission or intermission, and the frequent

association of emotional symptoms often render the differential diagnosis a task of considerable difficulty in the absence of pronounced hysterical stigmata. It is true that much has been done recently to unravel some of the complicated problems which these atypical cases present, but there remains still a large field for clinical investigation. Presumably, as our knowledge of neuro-pathology increases, and, it may be, as Dr. Ashley Mackintosh has suggested, by the adoption of more liberal views concerning the accepted cardinal signs, many conditions regarded as examples of psychoneurosis due to disturbance of the highest nervous centres will be referred to the initial stages of insular sclerosis.

In reviewing the multiformity and irregularity of the primary manifestations, it is indispensable to remember the anatomical lesions which constitute the malady; nor is it less important to bear in mind the fact, insisted on by Dr. J. S. Risien Russell, that from the standpoint of the nervous system the disease is, as a rule, a general one, affecting the whole of the cerebro-spinal axis from the cerebral cortex to the filum terminale, involving the ganglia, cranial and spinal nerves with their roots, and invading their peripheral branches. The sclerotic islets obey no fixed law, either in development or distribution; hence departures from the typical form are not uncommon. No two cases can be said to resemble each other exactly in their modes of onset or progress. As all parts of the nervous mechanism are open to attack, it is not difficult to understand the first blow of the disease will fall upon the locality which the morbid process has selected. The division of the malady into three recognised types, distinguished by Charcot and followed by nearly all the other writers on the subject, is, as Marie remarks in his tenth lecture, merely an artificial arrangement employed for the convenience of description, and the terms cephalic, spinal, and mixed or cerebro-spinal apply chiefly to the character of the predominating symptoms. Anatomically there is no such limitation to the morbid process. The four types constructed by Marie, based on the modes of onset and rate of progress, need not detain us; many, if not the majority, of chronic nervous diseases could be similarly subdivided. Far more important than any distinction of types seems to be a clear understanding that in insular sclerosis many departures are seen from the classical forms described by Charcot, and that the disease has remarkable periods of remission.

During the twelve months I acted as clinical clerk to Dr. Ferrier at the National Hospital, and had the advantage of his teaching, several examples of irregular type came under my notice. At his suggestion, with the kind permission of the medical staff, whose invariable courtesy I desire gratefully to acknowledge, and with the assistance of the house physicians, I have collected notes of the early manifestations in fifty cases recently under treatment in the wards, arranged in the form of a table, which may be considered a sequel to the interesting article of Dr. Mackintosh in the "Review of Neurology and Psychiatry" for February, 1903. From an analysis of the Table the following results are obtained:—

*Sex.*—There were 23 males and 27 females, which agrees with the view of Marie and others that in this disease the sexes are equally affected.

*Age.*—The incidence of age at the time of admission to the hospital is given in the decennial periods below—

Between 10—20	20—30	30—40	40—50	50—60
2	14	26	6	2 = 50

From these figures, the interval between the commencement of the symptoms to the date of admission must be subtracted. In the main the facts are in accordance with the experience of all neurological writers, that the majority of the cases occur in early adult life. The disease is rarely seen in children or after fifty years of age.

*Condition.*—In the 50 cases, 27 were married and 23 single.

*Occupation.*—The only circumstance worth recording is that 23 of the patients (nearly half) were engaged in domestic pursuits. There was nothing that could be

traced to the influence of toxic agents from certain trade occupations insisted on by Oppenheim.

*Causation.*—Although no definite cause could be discovered in the majority of the cases, it is interesting to note that the symptoms commenced either during pregnancy or soon after delivery in 6, after trauma in 5, after epidemic influenza in 5, after diphtheria 1, after sore throat (variety not known) 1, and in one case the patient referred his illness to a severe attack of gonorrhoea, which he said preyed on his mind to a great extent. Emotional causes were suggested in four of the cases, but these did not appear to be very definite. Sir William Gowers has called attention to the connection between disseminated sclerosis and the puerperium, beginning during pregnancy, remaining in abeyance until the next, and then becoming progressive. In the other cases the condition could not be traced to any antecedent illness or other known cause of the disease.

*Duration.*—In this calculation care was taken to ascertain as nearly as possible the actual time when nervous instability first appeared in a definite form. The result, taken from the statements of the patients, is given below.

Under 1 year, 6;	between 1 and 2 years, 11;	2 and 3 years, 3;	3 and 4 years, 7;	4 and 5 years, 9;	6 years 3;	7 years, 3;	8 years, 4;	9 years, 1;	10 years, 1;	13 years, 1;	14 years, 1=50.
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The longest period was 14 years, and the shortest about a month. The cases deserving of comment from their long duration are numbers 42, 5, 22, and 31 recorded in the Table.

In Case 42, the illness commenced with tenderness of the plantar surface of both feet, followed by difficulty in walking. At first the motor weakness was transient or intermittent in character. After a few months the disability became more pronounced, but although he had experienced several periods of partial remission, the paresis had been steadily progressive.

In Case 5, the patient first noticed difficulty in walking with staggering and girdle pain round the waist during her first pregnancy. After her confinement, she appeared to recover the power of walking completely, but three months later the same symptoms returned. She had four similar attacks subsequently with partial recovery on each occasion. For the last two years her gait has been so unsteady that she has never ventured out alone.

In Case 22, the primary symptom observed was weakness of the right leg and stumbling. Her right foot seemed to strike against any object higher than the surface. After treatment in the National Hospital she improved a good deal, but always noticed some degree of weakness in the same foot. She was, however, able to nurse her husband through a long illness, and after his death supported herself by her own industry. Subsequently her right arm and hand became affected.

In Case 31, a labourer first experienced difficulty in rising from his chair with staggering on attempting to walk. The symptoms were not at first continuous, but lasted several months at a time. He had tried several occupations, but had to give them all up one after another on account of his illness, and for the last seven months he has been unable to walk without assistance.

In Dr. Buzzard's interesting lecture on Insular Sclerosis, delivered at the National Hospital on February 9th, he described the details of four cases under his care which had existed with varying periods of remissions, two for 13 years, and the other two for 8 and 9 years respectively.

*Onset.*—The onset was sudden in 12 of the cases, and marked by a gradual invasion in 38.

The number of the former is relatively high compared with Dr. Mackintosh's series, 24 against 12½ per cent.

In the arrangement of the Table, the first symptom mentioned is that which the patients gave, as the earliest indication of their nervous disease. Divided into groups according to the usual classification the result obtained is—

TABLE REPRESENTING THE MODES OF ONSET IN FIFTY CASES OF MULTIPLE SCLEROSIS.

No.	Sex, Age, Condition.	Occupation.	Interval from Onset.	Onset: S. Sudden. G. Gradual.	Primary Indications of Nervous Instability.	Gait.	Deep Tendon Reflexes.	Plantar Reflexes.	Sphincters.	Cardinal Symptom
1	M 40 M	Clothier	3 yrs	S	Apoplectiform attack followed by stiffness of legs	Spastic	Exag. ankle clonus	Extensor	Precip. mict.	Nystag., vol. tremor, some dysarthria.
2	M 21 S	Porter	14 mos.	G	Unsteadiness of gait, fatigue in walking	Reeling and tottering	Exag. ankle clonus	Extensor	Precip. mict., inconst. constip.	Int. and head trem., blurred speech, pallor of opt. discs.
3	M 32 S	Blacksmith	4½ yrs.	G	Vomiting for 7 days followed by dysarthria	Ataxic	Exag. ankle clonus	Extensor	Precip. mict. constip.	Vol. tremor, scanning speech.
4	M 26 S	Hostler	18 mos.	G	Giddiness, staggering, sacral pain, amblyopia (transient)	Ataxic and staggering	Exag. ankle clonus	Extensor	Hesitating mict.	Nystag., vol. tremor, syllabic speech.
5	F 50 M	Domestic	13 yrs.	G	Difficulty in walking, staggering, girdle pain	Spastic and dragging	Exaggerated	Extensor	Precip. mict.	Nystag. vol. tremor.
6	F 20 S	Vocalist	3 yrs.	S	Headache, giddiness, transient amblyopia	Spastic and dragging	Exag. ankle clonus	Extensor	Normal	Nystag., pallor of opt. disc.
7	F 35 M	Domestic	5 yrs.	S	Diplopia with loss of power in R. leg	Spastic and staggering	Exaggerated	Extensor	Some inconst.	Vol. tremor R. arm and leg.
8	M 29 M	Hawker	6 yrs.	G	Difficulty in lifting R. foot, staggering	Ataxic and reeling	Exaggerated	Extensor	Inconst. of urine and faeces	Nystag., slow scanning speech.
9	F 21 S	Domestic	6 yrs.	G	L. leg gave way in walking, 3 epileptiform attacks	Spastic slightly	Exaggerated	Extensor	Some inconst. of urine	Nystag., scanning speech, opt. atrophy.
10	F 36 M	Domestic	5 yrs.	G	Weakness of L. arm and leg during pregnancy	Unable to stand	Exag. ankle clonus R. side	Extensor	Inconst. and retention of urine.	Pallor of opt. discs.
11	M 41 M	Chemist	18 mos.	G	Stiffness and fatigue in legs, chiefly left	Spastic and tottering	Exag. ankle clonus	Extensor	Precip. mict.	Nystag., syll. speech, L. opt. atrophy.
12	M 30 S	Clerk	1 yr.	S	Dysarthria, weakness of legs, giddiness	Unable to stand	Exag. ankle clonus	Extensor	Loss of control over blad. & rect.	Nystag., vol. tremor, syllabic speech.
13	M 37 M	Clerk	5 yrs.	S	Loss of power in legs, diplopia, inconst. of urine	Spastic and ataxic	Exag. ankle clonus R. side	Extensor	Diff. in starting mict.	Nystag. on upward movement.
14	F 38 M	Domestic	8 yrs.	G	Weakness of the legs, chiefly of the left	Unable to stand	Exag. ankle and knee clonus	Extensor	Normal	Nystag., vol. tremor, opt. atrophy.
15	M 28 M	Surveyor	2 yrs.	G	Dragging of R. leg, difficulty and delay in mict.	Ataxic and staggering	Exaggerated	Extensor	Difficulty in starting mict.	Nystag. on lateral deviation.
16	F 36 M	Domestic	5 yrs.	G	Weakness of L. leg during pregnancy, inconst. of urine.	Hemiplegic	Exag. ankle clonus R. side	Extensor	Inconst. of urine	Syllabic speech.
17	M 37 M	Labourer	2 yrs.	G	Weakness of L. leg after a fall	Ataxic	Exag. ankle clonus L. side	Extensor	Inconst. of urine and faeces	Nystag., slowness of speech.
18	F 32 M	Domestic	6 yrs.	S	Fatigue in R. leg, staggering, numbness of L. leg and inconst. of urine	Spastic and dragging	Exag. ankle clonus	Extensor	Precip. mict. and inconst. of faeces	Some int. tremor.
19	M 37 M	Omnibus writer	4 yrs.	G	Dragging of R. foot in walking	Unable to stand	Normal	Extensor R. side	Precip. mict.	Nystag. on lateral deviation, pallor of opt. discs.
20	M 32 S	Pianoforte worker	8 yrs.	G	Staggering gait, fatigue in walking	Unable to stand	Exag. ankle clonus	Extensor	Precip. mict.	Nystag. on lateral deviation.
21	F 20 S	Domestic	7 yrs.	G	Numbness and tingling of L. foot, dragging	Spastic and shuffling	Exag. ankle and knee clonus	Extensor	Inconst. of urine	Nystag. pallor of L. optic disc.
22	F 45 W	Domestic	10 yrs.	G	Dragging of R. foot, stumbling	Dragging and shuffling	Exag. ankle clonus R. side	Extensor	Normal	Slight nystagmoid movements on lateral deviation.
23	F 35 S	Domestic	3 yrs.	G	L. leg gave way in walking, followed by weakness of both legs	Spastic and dragging	Exag. ankle clonus	Extensor	Precip. mict.	Vol. tremor, opt. atrophy.
24	F 32 M	Domestic	3½ yrs.	G	Weakness of legs in walking, stumbling	Spastic, cannot walk	Exag. ankle clonus	Extensor	Inconst. of urine	Nystag. volitional tremor.
25	F 55 M	Domestic	4 yrs.	G	Stiffness of R. leg, sacral pain	Dragging, slightly spastic.	Exaggerated	Extensor	Inconst. of urine and faeces	Nystag. (fine oscillations).
26	M 46 M	Labourer	5 yrs.	G	Pain in sacral region, followed by staggering.	Shuffling, cannot walk	Exag. ankle clonus	Extensor R. side	Inconst. of urine	Nystag. syllabic speech, opt. atrophy, vol. tremor.
27	F 34 S	Charwoman	2 yrs.	G	Numbness in L. leg, difficulty in walking	Spastic dragging of L. leg	Exag. ankle and knee clonus	Extensor L. side	Normal	Nystag. in all directions.
28	F 36 S	Housekeeper	3 yrs.	G	Trembling of R. hand, inability to write	Spastic and reeling	Knee-jerks brisk	Extensor	Normal	Nystag. vol. tremor.
29	F 27 S	Packing-case maker	3 mos.	G	Numbness of both feet diff. in walking, staggering	Ataxic slightly	Knee-jerks brisk	Indefinite inconst. to ext.	Normal	Nystag., vol. tremor, l. arm.
30	M 33 M	Warehouseman	5 mos.	S	Stumbling of R. foot, trembling and weakness in both legs	Unable to walk	Exag. ankle and knee clonus	Extensor	Retention, constipation	Nystag. on lateral deviation.
31	M 30 M	Labourer	9 yrs.	G	Difficulty in rising from chair, staggering	Ataxic and reeling	Normal jaw-jerk present	Extensor	Normal	Nystag., vol. tremor, syllabic speech.
32	F 28 S	Domestic	8 yrs.	G	Numbness and weakness in both legs	Spastic dragging	Brisk ankle clonus L. side	Extensor	Delay in mict. constipation	Nystag., vol. tremor R. arm, pallor of R. opt. disc.
33	F 19 S	Domestic	4 yrs.	S	Giddiness, diplopia, numbness of three fingers R. hand	Dragging of L. leg	Brisk	Extensor L. side	Normal	Nystag. (fine oscillations).
34	M 28 M	Stableman	7 yrs.	S	Numbness, followed by weakness of both legs	Spastic and dragging	Brisk ankle clonus on R. side	Extensor	Precip. mict.	Nystag. syll. speech, opt. atrophy.
35	M 29 M	French polisher	2 yrs.	G	Dysarthria, diplopia, weakness and numbness of R. leg.	Ataxic and slightly spastic	Brisk ankle clonus on R. side	Extensor R. side	Precip. mict. constipation	Nystag., vol. tremor, syllabic speech.
36	F 26 S	Domestic	2 yrs.	G	Weakness of L. leg with dragging of foot	Unable to stand	Brisk ankle clonus	Extensor	Inconst. of urine	Vol. tremor.
37	F 24 S	Domestic	2 yrs.	S	R. facial paralysis, dysarthria and numbness of R. leg	Ataxic. ten. to fall to R. side	Brisk knee clon.	Extensor R. side	Normal	Nystag. on upward and lateral deviation.
38	M 34 M	Labourer	4 yrs.	G	Shaking of R. hand, fatigue in walking, staggering	Spastic and staggering	Brisk ankle clonus	Extensor	Diff. in starting mict. and constipation	Nystag. vol. tremor, staccato speech, pallor of opt. disc.

No.	Sex, Age, Condition.	Occupation.	Interval from Onset.	Onset: S. Sudden, G. Gradual.	Primary Indications of Nervous Instability.	Gait.	Deep Tendon Reflexes.	Plantar Reflexes.	Sphincters.	Cardinal Symptoms.
39	M 35 M	Stableman	4 yrs.	G	Trembling and dragging of L. foot in walking	Ataxic and spastic	Brisk ankle clonus	Extensor	Diff. in starting mict. and constipation	Nystag., pallor of R. opt. disc.
40	M 30 M	Butler	5 yrs.	G	Unsteadiness of gait, staggering	Staggering, dragging of L. foot	Brisk ankle clonus R. side	Extensor	Diff. in starting mict. and constipation	Nystag., pallor of opt. discs.
41	M 37 S	Engine driver	18 mos.	G	Diff. in lifting feet from the ground, chiefly left	Spastic	Brisk ankle clonus L. side	Extensor	Incont. of urine	Nystag., vol. tremor, slow syllabic speech.
42	M 35 S	Labourer	14 yrs.	G	Tenderness of both feet, increasing difficulty in walking	Spastic titubation	Brisk ankle clonus	Extensor	Normal	Scanning speech, vol. tremor, opt. atrophy.
43	F 15 S	None	6 mos.	S	Vomiting for 7 days, followed by weakness of legs	Unable stand	Brisk ankle clonus	Extensor	Precip. mict.	Nystag., vol. tremor.
44	F 45 M	Domestic	5 yrs.	G	Weakness of legs and staggering	Spastic and ataxic	Brisk ankle clonus	Extensor	Diff. in starting mict.	Nystag., vol. tremor, syllabic speech.
45	F 35 S	Domestic	4 1/2 yrs.	G	Scraping of L. leg. in walking, staggering	Unable stand	Brisk ankle clonus	Extensor	Precip. mict.	Nystag., vol. tremor, syllabic speech.
46	F 31 S	Domestic	7 yrs.	G	Unsteadiness in both hands, diff. in walking	Reel and staggering	Brisk ankle clonus	Extensor	Precip. mict.	Nystag., vol. tremor, syllabic speech.
47	F 47 S	Milliner	1 mo.	S	Numbness of left side, diff. in walking, diplopia	Tottering	Exaggerated	Extensor L. side	Incont. of urine	Nystag., vol. tremor.
48	F 38 M	Domestic	8 yrs.	G	Numbness of R. leg following abortion	Unable stand	Exaggerated	Extensor	Precip. mict.	Nystag.
49	F 30 S	Hospital nurse	4 yrs.	G	Loss of sensation in R. arm and numbness in both legs	Unable stand	Exaggerated	Extensor	Some incont. of urine	Nystag., vol. tremor, staccato speech.
50	M 25 M	Roadsweeper	8 mos.	G	Fatigue of L. leg, vertigo, staggering	Ataxic	Normal	Extensor	Some incont. of urine	Nystag., vol. tremor, syllabic speech, opt. atrophy.

- A—with cerebral or bulbar symptoms leading .. .. . 10
- B—with motor and sensory (combined) symptoms leading .. .. . 9
- C—with motor symptoms leading .. .. . 26
- D—with sensory symptoms leading .. .. . 5

It will be noticed that onset with motor weakness was observed in more than half the number of the cases, or at the rate of 52 per cent.

In the cerebral and bulbar group (A) are included—

- Onset with apoplectiform attack .. .. . 1
- Vomiting .. .. . 2
- Vertigo .. .. . 2
- Diplopia .. .. . 1
- Dysarthria .. .. . 1
- Dysarthria and diplopia .. .. . 1
- Headache (occipital) .. .. . 1
- Facial paralysis .. .. . 1

In the motor and sensory group (combined) (B)—

- Onset with numbness and weakness of both lower limbs .. .. . 2
- Numbness and weakness of one lower limb .. .. . 3
- Weakness of both legs and girdle pain .. .. . 1
- Weakness of both legs and numbness of one arm .. .. . 1
- Numbness and weakness of one arm and leg .. .. . 2

In the motor group (C)—

- Onset with weakness of both lower limbs .. .. . 0
- Weakness of one lower limb .. .. . 13
- Weakness of both upper limbs .. .. . 7
- Weakness of one upper limb .. .. . 2
- Weakness of one arm and leg (hemiparesis) .. .. . 1

- In the sensory group (D) —
- Onset with numbness followed by weakness of both lower limbs .. .. . 1
- Numbness of one leg after abortion .. .. . 1
- Tenderness of both feet, followed by progressive paresis of legs .. .. . 1
- Anæsthesia of right arm followed by numbness of both legs .. .. . 1
- Pain in sacral region, followed by staggering gait .. .. . 1

Remissions of the symptoms occurred in 26 of the cases, or at the rate of 52 per cent. In this estimate every admission of apparent improvement has been taken into consideration. The intervals and degrees of recovery were most variable, from slight amelioration to almost complete intermission, but in none of the cases did all the symptoms entirely disappear. Some amount of motor weakness or paresthesia remained. In one of the cases there were four remissions, in another three. Two remissions were described in eight, and one each in sixteen of the cases.

**Gait.**—At the time of admission to the hospital the various forms of gait noticed were, cerebello-spastic, 21, ataxic, 9; spastic and ataxic, 4; hemiplegic, 1; tottering, shuffling, and dragging, 4; unable to stand or walk, 11 = 50.

These figures agree with the text-books, that although almost every variety of gait is said to occur, the cerebello-spastic is the one most frequently encountered.

**Tendon Reflexes.**—The knee-jerks were brisk or exaggerated in 47 and normal in three, but the jaw-jerk was definitely obtained in one of the latter. Ankle-clonus was marked in 22 on both sides, in 12 on one side, and knee-clonus was present in 5 of the cases.

**Plantar Reflexes.**—Babinski's phenomenon was present in 41 of the cases on both sides, and in eight on one side only. In the other, the response was indefinite, but inclining to the extensor type.

**Sphincters.**—The organic reflexes were affected in 40 and normal in 10, but in the latter number one of the patients had suffered from incontinence of urine before admission, and had recovered control. The details given were as follows:—Precipitate micturition, 16



hesitating micturition, 8; incontinence of urine, 11; incontinence of urine and feces, 4; retention of urine and constipation, 1. In a large number of the cases the sphincter affection was a comparatively early feature of the disease.

*Accepted Cardinal Signs.*—The inconstancy of the so-called classical symptoms is illustrated by the figures given below:—

In the 50 cases now recorded—

Nystagmus, volitional tremor, and speech defects were observed in .. .. .	12
Nystagmus and volitional tremor in .. .. .	10
Nystagmus and speech defects in .. .. .	5
Nystagmus, or nystagmoid movements alone, in ..	14
Volitional tremor and speech defects in .. .. .	3
Volitional tremor alone in .. .. .	4
Speech defects alone in .. .. .	1
Pallor of optic discs alone in .. .. .	1

It will be noticed from these figures that nystagmus, or nystagmoid oscillations (chiefly on lateral deviation), were present in 41 of the cases, or at the rate of 82 per cent., and were the most constant of the so-called classical signs. The rate appears high compared with Charcot's estimate of 50, Uhtoff's of 58, and Marie's of 70 per cent., but in the present series the finer movements have been included. Volitional tremor and speech defects were observed in 21, or 42 per cent. According to Sachs all forms of dysarthria are seen, from what he described as "a speech tremor not unlike that observed in the early stages of general paralysis" to the ordinary scanning, staccato, or syllabic utterance. I have therefore grouped all forms of abnormal articulation under this head. In one of the cases pallor of the temporal halves of the optic discs was the only classical sign present.

Changes in the fundus oculi were noticed in 13 cases, at the rate of 26 per cent.

Optic atrophy on both sides .. .. .	7
Optic atrophy on one side .. .. .	1
Pallor of both discs (temporal halves) .. .. .	4
Pallor of one disc (temporal half) .. .. .	1

There is great variation in the figures given by the different writers on these changes. Those quoted by Ross are at the rate of 30, Buzzard 43, Uhtoff 45, and Mackintosh 47.5 per cent.

Uhtoff found complete optic atrophy in only 3 of the 100 cases on which he based his observations.

*Facies.*—The peculiar facies mentioned by Charcot—a certain vagueness of expression or stolid indifference to present surroundings, with some degree of mental enfeeblement, were noticeable in 17 of the cases.

*Sensory Symptoms.*—The researches of Hoffman, Erb, Freund, F. von Gebhardt, Oppenheim, and others have proved beyond all dispute that disturbances of common sensibility are of very frequent occurrence in disseminated sclerosis. Charcot qualified his remark, that they do not form a part of the clinical picture, by the admission "that formication and numbness in the enfeebled limbs of a transient nature were sometimes complained of." With the exception of the Babinski phenomenon they were probably the most constant of all the symptoms in the present series of cases. Thus, in the 50 now recorded no less than 42 referred to some kind of sensory disturbance (chiefly subjective in character) as a part of their illness, and in 8 only were the sensations perfectly normal. The paræsthesiæ comprised headache, pain over the sacral region, girdle sensations, cramp, numbness, tingling, and a feeling of what was described as deadness in the affected members. Objective symptoms were noticed in 7—analgesia, hyperalgesia, anæsthesia, and loss of muscle sense. In two of the cases trophic changes were observed—atrophy of limited groups of muscles. In 100 cases of insular sclerosis quoted by Hoffman, he found paræsthesiæ in 66 and objective sensory symptoms in 28, or together at the rate of 94 per cent., which correspond very closely with my figures. These observations support Dr. Mackintosh's view that disturbances of sensation are valuable aids to diagnosis in insular sclerosis.

*Conclusions.*—The inferences to be drawn from a study of the preceding notes are, I venture to think—

1. That the primary indicia of multilocular sclerosis are exceedingly variable both in distribution and degree.
2. The onset may be either gradual or sudden in character.
3. The most common mode of onset is with motor weakness of the lower limbs, more frequently at first limited to one leg; but that onset with cerebral, bulbar, or sensory symptoms forms a considerable proportion of the cases.
4. Pregnancy and the puerperal state, trauma, and the acute infections are not infrequent antecedents.
5. Remissions and intermissions of the symptoms of variable grades, and for indefinite periods, occur in a large number of the cases.
6. Many varieties of gait are observed in the disease, but the most common is the cerebello-spastic type.
7. The Babinski phenomenon is the most trustworthy and constant of all the symptoms.
8. The tendon reflexes are, as a rule, exaggerated, but in a certain number of the cases may be normal.
9. The organic reflexes are usually affected, and constitute an early feature of the disease.
10. Sensory symptoms (chiefly paræsthesiæ) are commonly complained of, either early or during the progress of the malady, and are of considerable diagnostic value.
11. Emotional symptoms, the peculiar facies, and some degree of mental enfeeblement (loss of memory) are not infrequently observed.
12. Of the so-called classical signs, nystagmus or the finer nystagmoid oscillations are the most frequent. Volitional tremor and defects of articulation are less commonly seen.
13. Optic atrophy and pallor of the optic discs are very frequent but variable symptoms.

## THE DYSPEPTIC ORIGIN OF THE MINOR SYMPTOMS OF BRIGHT'S DISEASE.

By DR. N. CHRYSOVERGIS,  
Of the Faculty of Medicine of Beyrouth.

WE are indebted to Professor Dieulafoy for having grouped under the common head of "the minor complications of Bright's disease" a series of manifestations not in themselves of any great importance and variously distributed which, he says, are frequently observed at the onset and in the course of Bright's disease; so much so indeed that from his point of view their recognition should place the practitioner on his guard and lead him to suspect the existence of chronic nephritis.

Speaking generally, these symptoms are attributed to the accumulation in the blood of toxic substances as the result of inadequate renal elimination. "Almost all the minor complications of Bright's disease," says Dieulafoy—"the cryæsthesia, the electric shocks, the cramp of the calf-muscles, and the itching—appear to me to be the consequence of a slight degree of uræmia. Graver complications, such as headache, attacks of oppression, gastric disturbances, and fugitive prostration, are due to a more marked degree of uræmic intoxication." This opinion, first brought forward by Professor Dieulafoy upwards of ten years since, does not seem to have attracted much adverse criticism. Moreover, it is indisputable that these minor symptoms of Bright's disease are, as a matter of fact, observed at the onset and in the course of chronic nephritis, and I agree with Lancereaux and Germain Sée that they are by no means solely the attributes of this affection. They are met with in subjects whose kidneys were, and have remained, intact, that is to say, although we are agreed in attributing them to a state of intoxication, I decline to attribute the origin of this intoxication to renal inadequacy. The title "minor dyspeptic complications" seems to describe them more accurately, indeed their pathogenesis is essentially due to excessive production of

toxins in the digestive tract and to the superabundance of gaseous formation in the gastro-intestinal canal.

In support of this hypothesis it must be premised that the symptoms in question are met with in dyspeptic subjects just as frequently, if not more so, as in the subjects of nephritis. The best plan will, no doubt, be to scrutinise them *seriatim*, at any rate the more important among them.

We will start with headache, vertigo, visual troubles, noises in the ears and lumbar pain. But does not every dyspeptic complain of these symptoms, not now and then, at distant intervals, but daily, in fact, almost constantly? These various malaises may be present in various affections of the digestive tract, either singly or variously associated, without it being open to us to elicit any sign that would justify our suspecting the existence of a renal affection. Even more significant is the fact that these symptoms get worse or improve coincidentally with modifications of the digestive troubles. Lastly, with regard to their duration, it is true that in most instances they are ephemeral, the generally-received view, but they may, under certain circumstances, last for several hours at a time, even for days, and recur every day for weeks together, so long as the digestive disturbances continue sufficiently pronounced.

Melancholia and prostration, which are also grouped among the minor symptoms of Bright's disease, are also very frequent in dyspeptics, in whom—a matter of daily experience—the temper is usually changed and depression is the rule.

With regard to the itching, it is far from uncommon in these subjects and it is often easy to demonstrate its non-dependence on renal insufficiency by putting the patient on a milk diet, that almost specific treatment of renal manifestations. Not only is the itching not relieved thereby, but in some cases the very treatment causes it to supervene. It has fallen to my lot to meet with a certain number of cases of this kind in persons suffering from gastro-intestinal atony, an affection which has the disastrous effect of depressing the motor activity of the digestive tract, thus promoting stasis, itself the proximal cause of auto-intoxication. I remember one case in particular; that of a man, *æt.* 45, dyspeptic and neurasthenic, who complained of general pruritus. His medical man, having erroneously diagnosed diabetes, he had been put on strict milk diet for ten days, and under its influence the dyspeptic troubles and itching had got worse. The urine, examined on two different occasions, was normal save for an excess of uric acid. I put this patient on a tonic and eupeptic regimen and in five days the itching had quite subsided.

With regard to the "electric shocks" which are assumed to be the initial signs of an attack of uræmia, it is well to note that the victims of this symptom have been so from their youth upwards. They are for the most part congenital neurasthenics, and, as we know, dyspepsia and neurasthenia are intimately associated. The symptom in question is due to spinal hyperæsthesia, a common symptom in neurasthenics. The slightest contact, even certain positions of the body, suffices to determine a reflex contraction of the dorso-lumbar muscles; moreover, one can determine these electric shocks in all neurasthenics simply by rubbing the spine.

Epistaxis, again, is a symptom not infrequently met with in dyspeptics, especially in elderly individuals in whom sclerosis has reduced the resistance of the walls of the blood-vessels, this moreover, being associated with heightened intra-vascular tension, due to the unsatisfactory state of the digestive tract. I remember in particular three dyspeptics (two of whom were also emphysematous) who suffered from frequent epistaxis, and I found myself unable to explain this circumstance on any other ground than a change for the worse in the gastro-intestinal troubles.

These remarks in respect of the minor troubles apply equally to those of a graver kind, and the latter are vastly more significant—*viz.*, symptoms involving the respiratory and circulatory functions—dyspnœa,

palpitations, œdema, polyuria, and pollakiuria, merely to mention the principal ones.

Whenever in a patient whose heart and lungs are sound we witness the supervention of repeated attacks of dyspnœa, we naturally think first of all of renal inadequacy (pre-nephritic dyspnœa), especially if these respiratory disturbances are associated with other minor symptoms of Bright's disease. Now, in my opinion, this dyspnœa is attributable to two different factors, both, however, arising from a common cause—*viz.*, the existence of digestive disturbances. We have, in the first place, the mechanical disturbance caused by gaseous distension of the stomach and intestines, in the second place there is the reflex contraction of the capillaries to which Potain called attention upwards of twenty-five years since, in connection with acute affections of the biliary canals and especially in gall-stone jaundice. To these two principal factors must occasionally be added spasm of the bronchioles and asthenia of the inspiratory muscles, which may play an adjuvant rôle.

I need not insist upon the various forms of this so-called pre-nephritic dyspnœa, for that would take me far from my subject. Suffice it to say that it may affect the form of Cheyne Stokes respiration or occur in a paroxysmal form suggestive of an attack of asthma, the form called by Max Einhorn "dyspeptic asthma." I have seen the latter form in two dyspeptics whose urine showed nothing abnormal.

The dyspeptic troubles do not fail to make themselves felt in respect of the cardiac function. Its influence is seen clinically by cardiac erethism, characterised by frequency of beat and increased force of the systolic contraction, in such wise that the first sound often acquires a vibratory quality. This cardiac erethism is complained of by the patients, who state that they can feel the beating of their heart and even suffer from time to time from attacks of palpitation with præcordial distress. The accentuation of the closure sound of the sigmoid valves is also almost constantly present in dyspeptics, especially when they are passing through one of the acute crises which are, after all, only an intensification of the habitual condition. It indicates an exaggeration of arterial tension caused by spasm of the peripheral arterioles or the vaso-constriction of the vascular system of one or several viscera which may, in the long run, determine cardiac hypertrophy. Auscultation also often reveals in these subjects the *bruit de galop*, a sign formerly regarded as pathognomonic of the prodromal period of chronic nephritis. Is not this exactly what have been described as the cardiac phenomena of the pre-nephritic period?

This cardiac erethism is usually associated with a similar erethism of the vascular system which is productive of certain phenomena of less significance, such as deadness of the fingers, pallor of the face, &c.

If now we pass on to the consideration of a symptom which is generally regarded as a sign of urinary inadequacy, *viz.*, the so-called pre-nephritic œdema, it is impossible not to be struck by the absolute similarity of this œdema and that seen in persons suffering from nervous exhaustion, who also suffer from dyspepsia; in both cases the œdema is usually insignificant in degree and fugitive in duration, limited to the eyelids, the face, to the malleoli, occasionally involving an entire limb, or it may be symmetrical. Even so, the cause is some vaso-motor disturbance, caused, no doubt, by toxic phenomena, but quite independently of the kidneys. These œdemata are characterised by vaso-dilatation of the affected region, following more or less marked and durable paralysis of the local vaso-motor apparatus consequent upon asthenia or inadequacy of motor innervation of the vessel walls. The slowing down of the circulation thus caused promotes serous exudation and constitutes the principal cause of this pre-nephritic œdema, which may be aggravated by the retention of chlorides when this takes place.

During the last few months I have collected notes of three cases of slight œdema, two of them in young females, *æt.* 36 and 26 respectively, and one in an old man, *æt.* 70. In all three cases the analysis of the urine

demonstrated the absolute integrity of the renal functions, and in one the excretion of chlorides was not in excess of the average. On the other hand, it was easy to satisfy oneself in all three cases as to the existence of dyspepsia and neurasthenia, and, as a matter of fact, the œdema disappeared under the influence of a merely antidyseptic and reconstituent treatment.

When circulatory troubles, with a tendency to congestion of the kidneys, predominate in certain dyspeptic subjects, as the result of fatigue or other excess, they are manifested by more or less copious polyuria, which lasts just as long as the acute dyspeptic crisis that started it. This view is confirmed by the fact that all the patients who are able to take careful note of themselves declare that the urinary secretion, independently of any other cause, is never as copious as on days when the dyspeptic condition is worse or when gaseous distension attains an excessive degree.

As to the pollakiuria, according to Dieulafoy it is due to exaggerated excitability of the mucous or muscular walls of the bladder. When, he says, the muscles of the body of the bladder alone are concerned the pollakiuria, early or late, is manifested by more or less pressing and frequent desire to micturate; whereas when the vesical sphincter is affected micturition is often followed by painful spasm. My own view also is that the pollakiuria is due to hyperæsthesia of the vesical mucous membrane, this, however, being caused by active congestion thereof. This state is strictly comparable with the condition of the gastric mucosa met with in the same group of affections which is manifested by vomiting occurring after the ingestion of a certain quantity of food or liquid. In the same way the bladder, of which the congested and consequently hyperæsthetic mucosa cannot tolerate any accumulation of urine, whence frequent and urgent calls to micturition.

To conclude this review of the principal so-called "minor signs" of Bright's disease, we need only refer to the cræsthesia. The excessive sensitiveness of neurasthenics to slight variations of temperature is well known, indeed, even the contraction of the flexor muscles of the fingers and the epileptiform attacks—these major accidents of Bright's disease—may take origin in the self-same order of things. Bouchard has witnessed their occurrence in the subjects of gastro-ectasis and he does not hesitate to attribute them to the absorption of toxic substances resulting from irregular fermentations in the dilated organ.

It is evident, therefore, that all the so-called minor accidents of Bright's disease may be, and often are, met with in dyspeptics. And let us not jump to the conclusion that we are dealing with an association of nephritis and gastro-intestinal trouble. We have often—and I wish to insist on this point—witnessed these accidents in persons who not only never afford any indication of renal disease but who never did so throughout their life's history and whose antecedents, moreover, failed to suggest any plausible cause of nephritis.

I will go even farther, for I do not hesitate to assert my belief that if a patient who has previously suffered from these accidents ultimately becomes the subject of genuine Bright's disease it would be rash to assume that the symptoms in question pointed to the existence of actual renal disease and to refer the onset of the latter to the date of these symptoms. On the contrary, I feel convinced that the etiological factors of these "minor signs" may, in the long run, act on the kidneys, so that these accidents prove not the existence of nephritis, but of a general auto-intoxication, which, later, gave rise to nephritis as an epiphenomenon, so to speak. What remains for me to say with respect to the "minor accidents of Bright's disease" will, I think, justify the views I have expressed.

I have pointed out that two principal factors give rise to these symptoms, one toxic (due to excessive production of toxins within the organism, and especially in the digestive tract), the other mechanical (excessive production of intestinal gases). These we will discuss separately.

It is more particularly in the digestive tract of dys-

peptics that the toxic substances are elaborated, consequent upon irregular fermentations. But to this source of auto-intoxication we must add another, which reinforces the action of the former—*viz.*, the disorganisation of metabolism. This has for result the production of numerous incompletely oxidised and therefore toxic principles; among them we may mention particularly the urinary pigments, regarded by Thudichum as extremely poisonous.

We must bear in mind, too, that this excessive production of toxic elements is further aggravated by the functional shortcomings of the antitoxic organs (liver, thyroid gland, suprarenal capsules, &c.), whence incomplete destruction of these very elements already in excess. The kidney, moreover, is to some extent an antitoxic organ, so that from this point of view it may be conceded to be occasionally in a state of meioptasia without on that account becoming impermeable. Far from being the cause of the auto-intoxication, the renal disturbance, under these conditions, is purely and simply the consequence. But if this double-barrelled toxæmia—excessive production and inadequate destruction of the toxic principles—is allowed to persist, structural changes will often result, either in the kidney or in some other organ which happens to be a *locus minoris resistentiæ*. In this way the patient may ultimately develop genuine renal disease, but it would none the less be an error to regard these minor symptoms as initial manifestations of nephritis, since they only supervene later. Consequently, if in a patient suffering from chronic renal disease we elicit the history, ten, fifteen or twenty years previously, of some of these signs, we shall be justified in referring them to a previously existing dyspeptic state and not to renal inadequacy, since the dyspeptic factor, by the gases and toxins to which it gives rise in excess, has, in the long run, exerted a powerful prejudicial action more powerful even than partial urinary insufficiency, the outcome of hypothetical renal lesions, in the production of the morbid phenomena.

Another argument which militates in favour of the dyspeptic origin of these troubles is the early period at which they make their appearance—*i.e.*, in young persons free from any history of infective influences capable of impairing the integrity of the renal apparatus as may, indeed, be demonstrated by the repeated analysis of the urine, which is shown to be free from any abnormal constituent.

Lastly, it seems to me that the statements of the patients themselves are worthy of attention when they affirm that these disturbances are more marked and severe when their chronic dyspepsia is from any cause intensified, becoming less aggressive, and even disappearing for a time, when the digestive function is discharged more satisfactorily. How often have I not been told that the passage of considerable quantities of flatus, freeing the digestive canal, has been immediately followed by relief of the headache, vertigo, visual troubles and the indescribable *malaise*, from which they had been suffering for several hours?

The action of intestinal flatus is double: first of all it is toxic when absorbed by the intestinal mucosa, and from this point of view the effects are common with those of the other toxic substances of digestive origin. Then, too, they exert a disastrous mechanical action, the distension of the gastro-intestinal canal inducing, through the reflexes, a series of disturbances which react on the circulation.

In view of these two factors—toxæmia and distension of the gastro-intestinal tract—we need only assume a more or less selective action on the vaso-motor centres (an action which may be promoted by a "vaso-motor diathesis") to explain readily enough the pathogenesis of these so-called minor troubles of Bright's disease, since they are attributable *en dernier ressort* to circulatory disturbances. In this respect we are in agreement with the classic writers, the point which I have undertaken to discuss being, not the pathological mechanism of these accidents, but the primary source of the intoxication which gives rise to them.

It is unnecessary to insist at length on the practical importance of the facts which we have brought forward. It cannot but possess an important practical bearing on the prognosis and treatment for us to know whether a patient who, for instance, presents crvæsthesia, pollakiuria or fugitive œdema is really a nephritic subject or is merely suffering from chronic dyspepsia. From this standpoint my opinion is clear enough: the symptoms in question do not justify the assumption of nephritis so long as the methodical examination of the renal functions fails to reveal any evidence of actual disease, such, for instance, as persistent albuminuria, oliguria, the presence of casts or other manifestation of the kind.

### Clinical Records.

#### THE DAVID LEWIS NORTHERN HOSPITAL, LIVERPOOL.

##### *Double Empyæma with Pulmonary Abscess.*

By K. W. MONSARRAT, C.M., F.R.C.S.E.,  
Surgeon, the David Lewis Northern Hospital, Liverpool.

THE patient whose case I wish to shortly relate was a dock labourer, æt. 26. He was admitted to the Northern Hospital on April 2nd, 1902, under the care of my colleague, Dr. Bushby, to whom I am indebted for the notes which were taken before he was transferred to the surgical side.

His illness commenced with headache, malaise, shivering, and pain in the left side of the chest, and on admission he had the usual signs of left basal pneumonia. This subsequently affected the whole of the left lung. For the first fortnight after admission he had irregular pyrexia, varying between 103.8° and 99°; albumin and blood were present in the urine. On April 16th the physical signs in his chest were, dullness over the left back, with diminished breath sounds and impaired vocal resonance; percussion dullness also at the left apex, with a few soft medium râles; the left pleural cavity was explored with a needle, with negative result.

At the end of this fortnight the temperature became regular, in that it rose constantly in the evening to about 102°, and fell in the morning to approximately normal.

On April 20th, he was transferred to my ward, as a second exploration at the left base had revealed pus. On the same day I removed 2 in. of the 8th rib behind, and evacuated about 20 oz. of inodorous pus, inserting a drainage-tube of large calibre.

In spite of this, his general condition did not improve; two days later the temperature reached 104° in the afternoon and continued to rise at night. The local condition at the left base improved, however; the lung advanced and the discharge decreased.

On May 20th the region of the left upper lobe was investigated with an exploring needle; the physical signs here had remained much the same—impaired resonance, diminished vocal fremitus, and indistinct breath sounds. Pus was withdrawn at the depth of an inch, and 1½ in. from the sternal margin.

The next day I removed a portion of the second rib; on palpation the underlying pleura and lung felt hard, dense, and indurated, and the exploring needle again withdrew pus. On incising this area an abscess cavity was opened, lined by broken-down lung tissue, and containing about 2 oz. of pus.

As I was not satisfied that this accounted for the dullness of the whole of the upper part of this side of the thorax, I passed the exploring needle in a direction upwards towards the apex and at once came upon a second collection of pus. On exploration this proved to be an apical empyæma, containing about 15 oz. The abscess cavity in the lung was packed with sterile gauze and a large drainage-tube was passed into the empyæma cavity from the front wound.

For the first week after this operation he still had a considerable rise of temperature at night, attributable to the fact that the upper empyæma cavity did not drain satisfactorily. The man was kept as far as possible on the left side, almost on his face, but he was

stupid or refractory, and turned on his back whenever he thought he was unnoticed. After the ninth day, however, his chart became satisfactory. The abscess cavity in the lung rapidly contracted. On June 7th the tube at the base was discarded, and a week later that in the anterior wound also. When discharged on July 12th his general condition was excellent and the wounds satisfactorily healed.

The interest of the case lies in the combination of conditions present. When, after the first operation, his condition showed no considerable improvement, Dr. Bushby formed the opinion that this was to be ascribed to an inflammatory process in the lung, and before the second operation foretold the probable presence of the abscess which was found.

With regard to the treatment, I followed my usual practice in removing about two inches of rib, in retaining a drainage-tube of large calibre from beginning to end, with no particular device for aspirating the cavity, in refraining from irrigation except under exceptional circumstances, and in getting the patient out of bed at the earliest possible moment, which in the average case is about a week after operation, but which was here delayed by the complexity of the conditions present.

### British Health Resorts.

#### IX.—NEWQUAY (CORNWALL).

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

THE much indented coastline of the Cornish peninsula furnishes numerous natural features desirable for a health station and a holiday resort. Within a comparatively small area great variety exists, but much discretion is needed in selecting suitable places for given cases. The south coast provides many sheltered and picturesque hamlets, admirably fitted for the requirements of the chronic invalid, which are deservedly growing in popularity as winter havens for the aged, delicate children and the subjects of respiratory affections. But of recent years the bold and rugged scenery of the northern portion of the peninsula with its rolling seas, rock-lined coast, and bracing climatic conditions, has become well known to the discerning few as an almost ideal resort, during summer days at least, for the convalescent, and particularly for the overworked in body and overwrought in mind.

Newquay is the best known of the North Cornwall health resorts. It is delightfully situated, and while open to invigorating sea-breezes nevertheless along the banks of the river Gannel admirable shelter may be obtained. Already the place is rapidly assuming the proportions of a small town, and several large, modern, palatial hotels are available for the luxury-loving visitor, while apartments of every description abound.

The immediate neighbourhood is rich in attractions and provides endless opportunities for the artist and naturalist. (a)

Dr. Arthur Hardwick, the Medical Officer of Health, has kindly furnished us with copies of his recent reports, from which we gather the following data:—The population is estimated at 3,300. The true death-rate is returned at 6.06 per 1,000. The birth-rate for 1903 was 13.6 per 1,000.

The mean temperature for last year was 51.3, the mean daily range being only 7.7. The number of days of bright sunshine is given as 286, the sunless days 79.

During the last eleven years, the mean humidity has been 84, the mean maximum temperature 55.9, the mean minimum temperature 47.2, the mean range 8.7, and the mean temperature 51.4. The daily average of bright sunshine is recorded as 4.8 hours. The mean barometric pressure was 29.94 inches.

We have carefully studied during a recent visit the right of Newquay to claim distinction as a desirable

(a) Consult the excellent manual, "Newquay: the Vale of Lanherne and Perranzabuloe," by Fannie Goddard, published by "The Homeland Association"; also Messrs. Ward, Lock and Co.'s convenient guide.

health resort. Nature has well fitted it for such a purpose and although art has done much to secure amusements and interests for the vigorous, pleasure-loving visitor we are of opinion that local enterprise might do much more to preserve and provide those characteristics and requirements peculiarly desirable for many lacking in robust health and absolutely essential for the ailing.

In the immediate neighbourhood of Newquay there are places which might well be made veritable sanatoria for those with phthisical proclivities or actually the subjects of tuberculosis.

We are strongly of opinion that Newquay would prove very serviceable for those conditions so commonly met with in children which a passing pathology termed strumous.

Newquay can be reached by the L.S.W. Railway or by means of the G.W. Railway. It is 266 miles from Waterloo and 297 from Paddington. By the former route Newquay can be reached in about 8½ hours, the latter portion of the journey being by coach from Wadebridge, a distance of 16 miles. Through carriages to Newquay are run by the G.W.R. on their excellent "Cornishman" corridor express trains.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, September 4th, 1904.

### CRYOGENINE AND PYRAMIDON.

In typhoid fever, cold baths constitute the best treatment, and each time the temperature reaches 102°, and every three hours night and day, the patient is placed in a bath of from 82° to 71°.

Nevertheless, an antithermic agent is sometimes useful. Sulphate of quinine is a very familiar remedy, more as a general tonic, however, than an antipyretic.

Two drugs are recommended to take the place of quinine—cryogenine and pyramidon; the former has been put on the therapeutic market by Lumière of Lyons, and has been favourably received by the profession. In a recent pamphlet, Dr. Boutheville indicated the advantages of the drug: complete innocuity, producing no congestion of the kidneys, nor diminishing the quantity of the urine.

On the other hand, its antithermic action is remarkable attaining a fall of nearly two degrees, but its action lasts only a few hours. The first day he gives 15 grs., the second 12, and the third 8, after which daily doses of 8 or 4 grs. according to the effect produced.

In Germany, pyramidon is preferred. Professor Valentin prefers to substitute the treatment by pyramidon for the cold baths.

In twenty-four hours he obtains almost complete suppression of the fever and delirium, while the frequency of the pulse diminishes. The dose he gives is very small, almost homœopathic—half a grain every two hours night and day; in severe cases he gives one grain, while in children he does not exceed one-fifth of a grain. The remedy is administered during the whole course of the malady. These fractional doses are also recommended by Dr. Byk, who has treated in this manner several cases, with invariable success.

### PAIN IN THE EAR.

Hydrochlorate of morphia, grs. vj; sulphate of atropine, grs. ij; water, ℥ss. Six drops in the ear at night.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 4th, 1904.

### PSEUDO-HALLUCINATION.

PSYCHOLOGISTS are ready to tell us that all mankind

are living in a state of deception without knowing it. Heveroeh recently brought a boy, æt. 14, before the Bohemian meeting in Prague who knows this, and is quite conscious of the deceit. If he concentrates his mind on some object not immediately before him or connected with the outer world, he can see swarms of fairies with whom he can converse and indulge with them in their pleasures and pastimes. Pain is not mentioned. He is perfectly aware of the duplicity and sometimes has difficulty to shake it off. In straining or making an effort to grasp the meaning of any mundane truth he becomes imperceptibly transformed to a new state, or what psychologists call his "real state." Is this an instaromnium for the deluded? Heveroeh further informs us that this is the son of an alcoholic parent, and fears that this boy is not free from the vice, even at this tender age, which entirely destroys the charm of our philosophy.

### CORRECTING POSITION.

Ostrcil at the same meeting gave a description of a method which he has adopted in converting a face presentation into an occipital presentation. Schatz and Thorn have both promulgated a method of their own which is fundamentally to press the shoulders of the foetus backwards and upwards, inducing the head to rotate forwards and upwards. Ostrcil has modified this, and contends that his methods are better than those of his predecessors, for his can be performed by himself, while the others require an assistant. The whole can be done without any untoward circumstances in the parturition.

### PECULIAR TYPE OF DEGENERATION.

Heveroeh exhibited a girl, æt. 11, with a hereditary form of mental degeneration. The girl often left home and wandered about distant neighbourhoods telling falsehoods of the terror she had of returning to her parents. Her peregrinations were always extended, and her deceit proportionately increased. She always locked herself in her own room, refused to go to school, and at the beginning of her aberrations she was attacked with cramp, becoming pale, with the head turned round and jerking of the foot. She continued sullen and never spoke, but gave signs of great hunger and thirst. These symptoms are uncommon in epileptics, who seldom consciously cover their morbid misfortunes by falsehood. Since the meeting, it is reported that the girl has been found murdered.

### SUBCUTANEOUS INJECTIONS OF GELATINE.

Moll related his experiments on guinea-pigs and dogs with intravenous injections of gelatine. He found that the fibrin of the blood was greatly increased, while the agglutinating power of the red blood corpuscles prevented extravasation. Other albuminoid substances injected, or applied subcutaneously, increased the fibrin, which also favoured coagulation. The action of gelatine declared itself within twelve hours and not beyond twenty-four hours after injection. It is calculated that the blood contains three to four times as much fibrin after this period for three days as is found in the normal condition. Taken by the mouth gelatine has no such effect. It may be mentioned also that sterilisation does not destroy the powers of hæmostasis, thus pointing to the practical application of gelatine as a valuable method of treating obstinate hæmorrhage, although the effects cannot be expected immediately. In practice it may be valued more as a prophylactic than an immediate hæmostatic. It may be noted that the subcutaneous injections and increase of fibrin in the blood do not disturb the digestive organs. He exhibited coagula to the members, which substantiated

his description of agglutination and thickening of the blood. As a general rule, when any albuminous body is injected subcutaneously, leucocytosis is produced along with the increase of fibrin.

In the discussion Imhofer said that he had employed gelatine subcutaneously with the best results for local hæmorrhage, such as in epistaxis. He found it excellent when applied locally with pledgets of carbolised lint to a bleeding surface. Munzer thought that the danger of injecting gelatine should not be under-rated. Besides the weakening effects that usually followed, literature was not without its example in post-mortems, where the *exitus letalis* followed suddenly after the injection of gelatine for aneurysm. Nonne, of Hamburg, has put on record a good example as a warning, where a young man, full-blooded, exhibited a slight pulmonary hæmorrhage which induced the attendant to inject gelatine. The man died suddenly, and in the lung were found a few emboli which had been the cause of death. If every drug and method of treatment has failed, gelatine may be resorted to as a last resource.

### The Operating Theatres.

#### GREAT NORTHERN HOSPITAL.

OPERATION FOR DISTENDED GALL-BLADDER.—Mr. PEYTON BEALE operated on a woman, æt. about 50, whose history was as follows: About five weeks before admission she observed her abdomen becoming larger with a sense of fulness and increased weight. As far as could be ascertained she had had no other symptoms except a slight malaise till a few days before admission, when she was seized with violent pain in the right iliac region, in the epigastrium and in the back; this was accompanied by a rise of temperature to 103°. On admission there was felt in the abdomen a movable tumour, occupying the right iliac region in the position of the cæcum; the tumour was about the size of a foetal head, apparently globular in shape and very hard; it was fairly freely movable and its manipulation gave rise to considerable pain, referred chiefly to the epigastrium and the dorsal spine; the temperature was now normal, but the patient looked and seemed ill. The medical man who sent the case considered it to be a suppurative appendicitis. This, however, was negated by the mobility of the tumour and its globular shape. As it was impossible to make any definite diagnosis, and as the woman's general condition was becoming worse, the following operation was performed: An incision of about three inches was made about two inches anterior and parallel to that usually employed in performing lumbar colotomy. On opening the peritoneum a large globular tumour, very hard to the touch, was felt and it was obviously a very much enlarged gall-bladder. After separating a few adhesions it was without difficulty brought out through the wound, and it was then seen to be a sausage-shaped swelling containing fluid at very great tension. It was then punctured and thick treacly-looking bile escaped. The gall-bladder was next opened freely and four large gall-stones were evacuated, together with about a pint of the inspissated bile. The gall-bladder was washed out with hot, sterilised water, the interior being carefully examined to make sure that there was no stone in the duct. The lumbar incision was then closed with the exception of one inch, to the edges of which the open gall-bladder were stitched. Mr. Beale said that the history of the case was so misleading

that any diagnosis before operation was impossible: the tumour seemed to be globular when felt through the abdominal wall because there were adhesions between it and the liver, stomach, &c., around its upper part; it had dragged the liver down to such an extent that the tumour was lying on the cæcum; as it turned out the incision was in the most favourable position that could have been chosen, though, of course, it was much too far back and too low down to be of use in any ordinary case of enlarged gall-bladder. As it was it allowed the gall-bladder to drain thoroughly well, and Mr. Beale proposed in about a week's time to sew up the opening in the gall-bladder and drop the viscus back into the abdominal cavity. He had come across a good many enlarged gall-bladders which had been mistaken for enlargement of the kidney, but had not before seen one which was resting on the cæcum. He said that he had made the incision so far back because he was in the habit of using this incision for reaching appendix abscesses, and at the time of operation and from the previous history this case was thought not unlikely to be of such a nature.

#### MIDDLESEX HOSPITAL.

OPERATION FOR THYROID CYST.—Mr. KELLOCK operated on a man, æt. 24, who had been admitted for a tumour situated in the right lobe of the thyroid gland, which had been present for some years, and which latterly had somewhat rapidly increased in size, but had given rise to comparatively few symptoms. The patient was a thin, anæmic man. Situated low down in the right lobe of his thyroid gland was a tumour rather larger than a pigeon's egg, which was little noticeable when the patient was at rest, but when he performed the movements of deglutition, it became very evident, rising up, as it were, from the deep parts of the neck behind the clavicle. The growth felt firm and circumscribed, but its situation rendered it difficult to say whether fluctuation could be obtained in it. The rest of the gland appeared unaffected. Except that he was somewhat anæmic the patient's general condition was good. The man having been anæsthetised, a vertical incision, about three inches in length, was made slightly to the right of the middle line, reaching downwards almost to the upper angle of the sternum. A few bleeding vessels in the soft parts having been secured, the right sterno-hyoid and sterno-thyroid muscles were separated and held aside by retractors, and the lobe of the thyroid containing the tumour exposed. A slight incision having been made in this, the tumour itself came into view. It proved to be a somewhat thin-walled cyst, and on an attempt being made to shell it out from the substance of the gland, the wall ruptured, and the contents, which consisted of about two or three drachms of fluid glistening with cholesterin crystals, escaped. The edges of the opening in the cyst were then taken hold of, and the entire cyst wall easily detached and removed. The hæmorrhage from the cavity was slight, and easily controlled by plugging for a few minutes with gauze. A small drainage-tube was then inserted into the cavity in the thyroid gland, and the superficial structures and skin closed round this, with fine silk for the superficial structures, and horsehair for the skin. A dressing of cyanide gauze was then lightly applied by means of a bandage passed round the neck and under the arms. Mr.



Kellock said that unilocular cysts of the thyroid were comparatively rare in men. Before the operation it had been difficult to say whether the tumour was a single cyst or a multilocular cystic adenoma. It was possible that it was of the nature of an adenoma with one large cyst, but the thinness of the wall and the character of the contents, the latter being quite fluid and containing many cholesterin crystals, would suggest that it had some other origin. He further pointed out that formerly the treatment of these cysts consisted in either simple tapping with or without the injection of some slightly irritant fluid, or by incision and drainage, but the operation he had just performed showed how comparatively easy a matter it was to deal with such things in a more radical manner. The drainage-tube which had been left leading down to the cavity in the thyroid was for the purpose of preventing any accumulation of blood, which might be injurious from its pressure, and this tube would be removed, he hoped, in the course of thirty-six or forty-eight hours. It was important, too, in these cases, he thought, to apply a very light dressing for the same reason, and to keep the patient's head and neck quite still, lest any movement might set up fresh bleeding from the damaged surfaces of the gland.

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### The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, SEPTEMBER 7, 1904.

#### HOSPITAL ISOLATION AND SCARLET FEVER.

THE articles on scarlet fever and its treatment by hospital isolation, contributed to our columns by Dr. Killick Millard and Dr. Hubert Biss, deserve careful study. It would not be wide of the mark to say that until three or four years ago, when Dr. Dean Marriott, of Nottingham, and Dr. Killick Millard raised the question of the utility of fever hospitals as controlling factors in the spread of infectious diseases, no serious doubt on the subject was entertained by sanitarians. Indeed, it was a prime article of the hygienic creed that isolation hospitals, as they are generally called, formed the chief bulwark

of defence against infection. The opinions of those who at that time courageously attacked this belief were scouted as ridiculous, and with feathers much ruffled at the audacity of their critics medical officers of health endeavoured to treat the onslaughts as frivolous and beneath contempt. But the spirit of the reformer is stimulated by rebuffs, and by dint of in-season and out-of-season efforts to win adherents to their views, Drs. Marriott and Millard gradually gained the ear of an increasing number of medical men. The general attitude of the profession towards the question was reflected in the medical journals, and, one by one, these organs, from showing a front of uncompromising hostility, have come to lend their voice, feebly and hesitatingly it is true, in aid of the demand formulated by Dr. Millard for an intra-professional inquiry into the subject. The question at the moment stands in this position. The critics of the isolation hospital system, or, as they more correctly describe it, the aggregation hospital system, have brought forward good evidence to show, first, that the hospitals have not been a striking success as preventives of scarlet fever incidence, and, secondly, that the hospitals have many grave drawbacks. Does the good of the system outweigh the evil, and, if so, is the amount of good effected commensurate with the enormous sums expended? Since a widespread feeling of dissatisfaction exists, we think that such an inquiry as that suggested ought not to be postponed. For it must be remembered that this agitation is not a hole-and-corner affair. Many medical officers of health have individually and collectively expressed their approval of the proposition; the leading journals of the profession have now given it their support; and lastly, at the Congress of the Royal Institute of Public Health at Folkestone this summer a motion in favour of inquiry was passed by a large majority. The question, then, may be described as a burning one. It will be noticed that Drs. Millard and Biss, and, indeed, most of those who have taken a prominent part in the matter, have confined their attention to the isolation of scarlet fever. In this they are wise, for whatever may be the case with the other infectious diseases, it is in the instance of scarlet fever that the anomalies are most striking. As Dr. Biss showed in the first part of his paper, the prevalent type of scarlet fever to-day is an exceedingly mild one, and it may well be questioned whether so benign a disease deserves the lavish expenditure of money now bestowed upon it. Dr. Biss' present contribution is a particularly valuable one, not only for its erudition and insight, but for the temperate and scientific manner in which he handles a question which, as he justly says, should not be regarded as polemical. The considerations he adduces from the past history and present condition of scarlet fever in this country are exactly those which should possess the mind of anyone who wishes to do justice to this important matter. The evils, he maintains, are inseparable from aggregat-

ing such people, especially when the bulk of those people are young children, and deserve serious attention. The records of post-scarlatinal diphtheria, post-diphtheritic scarlatina, measles, whooping-cough, and chicken-pox, which belong to all fever hospitals, however well managed, have to be weighed against the good that patients may derive from their sojourn in these institutions, and one cannot look to any marked diminution under this head till the present ward system is replaced by the much more expensive cubicle arrangement which is found in some of the Continental hospitals. After all, however, the crux of the whole question is whether there is, or has been, as the result of the wide multiplication of fever hospitals, any marked diminution or restriction in the prevalence of scarlet fever. This, as Dr. Millard observes, is a point that must eventually be decided by statistics, and without a combined inquiry it is difficult to see how far-reaching and authoritative figures are to be obtained. The belief that by separating patients suffering from scarlet fever from their healthy fellows a certain number of attacks must be prevented is a natural one. Dr. Boyd gives in the August number of "Public Health" details of a careful investigation he made at South Shields, which tended to show that scarlet fever has of late years prevailed more largely in the better class districts than in the poorer ones—a result he is inclined to attribute to a larger number of cases of the disease being removed to hospital from the less well-to-do parts of the town. But without general inquiry and free comparison of various towns no final or satisfactory solution of the problem can be expected, and we should strongly urge such an inquiry ourselves. Whatever it may bring to light, we think that opponents of the hospital system will prove to be right in saying that the success of that system has been far from commensurate with the predictions of its founders.

#### EPILEPSY OR DRUNKENNESS?

As members of a scientific profession medical men are closely interested in the question of criminal law administration. At any hour of the day or night the general practitioner is apt to be summoned by the police to attend a sick or injured person, a service for which he is paid a miserably inadequate fee, obtainable only through the medium of circuitous official channels. If the General Medical Council were really a body concerned with the interests of the profession, this small but irritating matter of police attendance fees would long ago have been settled on a satisfactory basis. The duties of the medical man thus summoned are often of a most difficult and responsible nature. He has to determine between the various forms of insensibility, and upon his decision may rest the reputation and sometimes the life of a fellow-citizen. As a rule, in the cases where disaster follows the confusion of various other forms of insensibility with that due to alcohol a surgeon has not been called by the

police. On the whole, the official police surgeons are a highly-trained and experienced body, in whose hands the risk of erroneous diagnosis is reduced to a minimum. The chief effect of the present system is that they are not called often enough, because the police trust their own judgment and do not realise that a drunken man is in a position of more or less imminent danger. The majority of the police throughout the United Kingdom are untrained even in the elementary knowledge of ambulance work, whereby they would be able to recognise many of the conditions of sickness that are commonly mistaken for drunkenness. With a little training, for instance, any constable of ordinary intelligence could learn how to distinguish epilepsy from alcoholism. A modicum of such elementary knowledge would have recently saved a London magistrate a good deal of vexation. An unfortunate epileptic, who is said to be a total abstainer and of irreproachable character, was brought up in custody by the police on a charge of drunkenness. The father of the accused states that he was prevented going into court to give evidence as to his son's liability to epileptic seizures. However, other evidence was forthcoming, and the magistrate, Mr. Plowden, discharged the prisoner with the unfortunate remark that he would give him the benefit of the doubt. It is not clear why a man who has been taken into custody on an unfounded charge, and kept for the night in a police cell, should be dismissed with a "whitewashing" of that dubious and grudging kind. The accused was either drunk or not drunk, he was either an epileptic or not an epileptic, he was either innocent or guilty of the charge of drunkenness. It was perfectly open to the police to ascertain the fact as to the epilepsy, which would have afforded immediate confirmation or otherwise of that part of the defence. Instead of so doing, the police, if we are to take the statement of the father, excluded such evidence from court. The fault appears to lie in the police system, which regards it as a stain on its efficiency if a charge be not substantiated at all hazards. A great deal of the possibility of minor police injustice or tyranny would be avoided by having all sick and insensible persons in custody examined by a medical man. Another safeguard would be the possibility of immediate appeal from any criminal judgment, no matter how trivial the case. It is clearly intolerable that a respectable citizen should be shut up in a police cell because the police have had neither the desirable knowledge to recognise the fact of his being in a state of epileptic seizure nor the sagacity to consult a surgeon as to his condition. Still more intolerable is it that he should be dismissed next morning by the magistrate with a curt remark that left the police charge in doubt. The blind acceptance of police testimony without any attempt to bring corroboratory evidence constitutes a radical defect in minor criminal proceedings. The history of epilepsy, to say nothing of the strictly temperate habits of accused, would have been

confirmed in a few minutes by a couple of friends or relatives in the witness-box. The matter is one of universal importance. At any moment any citizen, no matter what his standing or respectability, may be taken ill in the street and carried off to a police cell. In many cases the error has ended in a tragedy. It is time the whole matter were investigated by an authoritative Royal Commission so that the margin of error in the case of persons taken into police custody in a state of unconsciousness may be reduced to a minimum. Meanwhile, the medical profession, which is brought into direct daily contact with the disastrous defects of the present police system, may do much to educate the public and to indicate the way of reforming a force which, in spite of its errors, we could not do without.

### Notes on Current Topics.

#### Typhoid Infection.

We are always inclined to become somewhat stereotyped in our beliefs and practices, and hence it comes that having learned, quite correctly, that faecal contamination of drinking water is the commonest method of spreading typhoid infection, we proceed in the main as if it were the only possible method. Recent experience has proved, however, that various other means of infection have more than a theoretic interest, and that a pure water supply is not the sum-total of safety. India and South Africa have shown that wind-blown dust is under some circumstances of much greater importance than drainage as a factor in the contamination of water, while its influence affects all foods and drinks as well, unless proper precautions are taken. Various observers have shown, too, that flies may, and do, act as carriers of infection. Much more important, however, than either dust or flies are the deductions that follow from the discovery of typhoid bacilli in the urine. It is now known that not only during the height of the disease, but often for weeks after convalescence, the urine of typhoid patients contains large numbers of live bacilli. There can be but little doubt that this constitutes a serious source of infection which, up to the present, has been entirely overlooked. In the treatment of typhoid fever it has long been the custom to destroy or disinfect the stools, while little care has been taken to deal specially with the urine. In reality, it should be handled with the same extreme caution with which a bacteriological worker treats the virulent cultures in his laboratory. It should be remembered, too, that patients having left hospital as cured may still be passing bacteria in their urine, and may thus become a source of danger to others. Consequently, equal care should be taken to be sure that the urine of typhoid patients is free from bacteria before they leave hospital as is at present taken to make sure that diphtheria patients no longer have diphtheria bacilli in their mouths.

#### Sir Thomas Browne.

THE proposed memorial to Sir Thomas Browne, to which members of the medical profession are asked to subscribe, has drawn a strong protest from Dr. Conolly Norman, of Dublin, who in a contemporary appears in the character of *advocatus diaboli*. "Science and humanity," says Dr. Norman, "are the watchwords of our profession. The author of 'Religio Medici' was neither scientific nor human." These charges he proceeds to prove, we think, with considerable success, by reference to Browne's conduct in the trial of two country women at Bury in 1664, on a charge of witchcraft. The principal count against them was that by their machinations certain children had been afflicted with "fits." Browne, being present in court, and asked by the judge for his advice, "declared that he was clearly of opinion that the fits were natural, but heightened by the devil, co-operating with the malice of the witches, at whose instance he did the villainies." Influenced by this expert opinion, the jury convicted, and the women were executed. It may be argued that belief in witchcraft was universal in Browne's time, but this is by no means true, as it should be remembered that he was contemporary with Hobbes, Butler and Locke. And one of the many points on which he prides himself is that he is neither fanatic nor enthusiast. Dr. Norman makes out a good case on the two charges on which he indicts Sir Thomas Browne, and many lovers of literature who demand thought as well as style in a writer will not be sorry to see this depreciation of one whose reputation is greatest among those who have never opened his works.

#### Serum-therapy.

ONE of the most interesting discussions which took place at the meeting of the British Medical Association a few weeks ago was that on the serum treatment of disease. The Executive acted wisely in inducing the medical and pathological sections to combine for the purposes of discussion, since the subject is at present not merely one of primary practical importance, but has also theoretical bearings of the widest. Discussed, as it is bound to be in such a gathering, from the very different standpoints of clinical and laboratory experience one might have expected greater differences of opinion than actually appeared. In fact, such differences as did appear were rather superficial than real, and on the whole some important results stand out. The main point is that the anti-bacterial sera, of which anti-streptococcus serum is the best known, may definitely be regarded as valueless, while there is a possibility of their being actually deleterious. The clinical evidence has never been decisive, while on theoretic grounds the arguments against them are so strong that, as Dr. Bullock put it, "no respectable laboratory thinks of manufacturing them now." As regards the antitoxic sera, on the other hand, such as the anti-diphtheritic and anti-tetanic preparations, they are now outside the region of

controversy as remedies of established worth. In regard to the method of their use, it is well to remember Dr. Martin's advice, based on experimental grounds, that in urgent cases the serum should be administered intravenously rather than subcutaneously, as a speedier result can thus be obtained.

#### Interrupted Circulation in Treatment.

As long ago as the time of Ambroise Paré, damming of the circulation above a fracture in a limb was recommended as conducive to rapid healing. The treatment never seems to have been widely adopted, though many writers at various times mention it as a successful measure in local lesions. To Dr. Ewart, of St. George's, is due the credit of reviving the method, and applying it with success in cases of rheumatoid arthritis. He empties the veins of blood as far as possible by raising the limb he is about to treat, and by firmly stroking it. He then applies a tourniquet tightly above the affected joint for half a minute or longer, and relaxes it. The application of the tourniquet is, of course, accompanied by blanching of the part, while its removal is immediately followed by a sudden hyperæmia. This alternation of anæmia and hyperæmia is repeated rapidly four or five times. The treatment may be given once or twice a day. In the cases treated by Dr. Ewart he has noticed a rapid decrease of swelling and diminution of stiffness, and he thinks the treatment may have a wide applicability.

#### The Fear of Death.

A WELL-KNOWN writer—we think it was Mr. George Meredith—made the remark some time ago that our profession, in common with the clergy, was injuring the English race by increasing their fear of death. We suppose there is a certain truth in the charge that medical science increases the dread of death, since it makes death appear more avoidable than formerly. While "man is mortal" is as universal a law as ever, yet each man's mortality at a particular moment, being known to be governed by the conjunction of certain natural laws, allows a possible chance of escape. We are not as ready to fold our hands and say "kismet" as formerly in the presence of an epidemic; on the contrary, we are inclined to ask who is responsible, for, as someone has said, for every epidemic of typhoid fever someone should be hanged. If death here and now has thus become less a matter of certainty and less a matter of course than formerly, its very unfamiliarity makes it more feared. Life, too, has a sacredness in our civilisation which is comparatively a new thing, and is bound to make the negation of life seem a greater evil than in old times. But, is it true that there is in reality more dread of death than formerly? We think that this fear of death is in truth a very exaggerated thing. In health one naturally and properly wishes to remain alive, but beyond this we think whatever fear may be present is rather of suffering than of death.

Those who have seen many people die of disease are inclined to the view that dread of death is comparatively rare. Death is natural, and the person meets it as naturally and impassively as at the end of a busy day he meets his night's sleep. Where death is dreaded it is rather for the sake of those left and more for sorrow at breaking a happy career than for anything in the essence of death itself.

#### Hungry School Children.

IT is a self-evident fact that food must be furnished before any mental pabulum can be properly assimilated. The revelations of recent evidence before the English Inter-Departmental Committee on Physical Deterioration certainly seem to show that failure to recognise this principle, either from wanton neglect or abject poverty, is only too prevalent among the poor of our crowded cities. According to the headmaster of one of our Board schools, 12 to 15 per cent. of the children are unable to give their minds to their lessons on account of actual hunger, which condition was proved to exist in several cases by the eagerness with which some children devoured stale crusts of bread given to them as a test. During hard winters the proportion of famished scholars in the poorest schools is stated to be even higher. In some instances it is not so much the want of food as its quality and the irregularity in meal-times that chiefly touch the physical welfare of the children. The matter was more than once fully discussed by the late London School Board, who appointed a Special Committee in 1898 to consider the question. It was then resolved that in case of culpable neglect of a parent to provide food for any child the Board should have power to prosecute for cruelty, but this proposal was defeated by a full Board. Private enterprise and philanthropy have done much to ameliorate the impoverished conditions of school children, and on this account educational authorities have been unwilling to urge that the matter should become an item of public expense. Dr. Macnamara, M.P., has recently drawn attention to the whole subject in the daily press, and he is of the opinion that the support of the great urban educational authorities should be secured before pressing the legislature.

#### The Demoralisation of the Consumptive.

THE view that certain temperaments are peculiarly prone to particular forms of disease was firmly held by physicians of the old school. It is now customary to assume the air of the agnostic in regard to much in medicine which cannot be demonstrated by so-called methods of precision. But every thoughtful physician knows that in his own and his patient's physiological upbuilding, and in the initial action and reaction between them, there are elements altogether beyond the ways of the mere laboratory investigator. Some day, perhaps, we may unfold something of the closely draped mystery of the psychology of the pathological. Meanwhile, much that is of

suggestive value has accumulated in regard to the psychology of the phthisical. We do not intend to describe the various traits so frequently conspicuous in the character of the consumptive patient, but are desirous of urging on all who are in any way responsible for the management of these cases the paramount importance of recognising those psychical features which, if rightly controlled, make for mental and moral development, and if neglected lead to as slow but sure deterioration of moral character. We know, as the result of much personal investigation of so-called sanatorium life, that at the present time in connection with what is known as "open-air" or "hygienic" treatment of consumptives there is often a deplorable ignorance of the psychical requirements of the healthy life, and in many institutions the procedure adopted is such as tends to develop selfish, morbid introspection and moral decadence. In short, there is danger in the eagerness to improve physical condition of altogether forgetting the culture of the psychical side of the patient, and so there is in process much that is making for the demoralisation of the consumptive.

#### Five Abdominal Sections in Four Years.

OUR American brethren have never been reproached with want of courage in the pursuit of surgery, and they have certainly educated their patients to look upon "the knife" with much less horror than our own conservative population usually entertain towards it. A certain Mrs. B., a patient of Dr. Howard Crutcher, appears to have become so much inured to abdominal operations that he had finally to dismiss her from his *clinième* as he assured her that it was against his principles to do half a dozen laparotomies on the same patient. In 1894 Mrs. B. was first seen and operated on for rupture of a large pelvic abscess. Everthing went well, in spite of a gloomy prognosis that Dr. Crutcher felt it his duty to give, but some months after convalescence a ventral hernia developed. A second and completely satisfactory operation was performed for its relief. About a year after this, Dr. Crutcher was called to see her for the third time, and found that she had appendicitis. On opening the abdomen he discovered a gangrenous appendix with two perforations; appendicectomy was done, and the patient again recovered. In 1896 Mrs. B. consulted him again, this time for a growing swelling in the pelvis. After a period of observation, Dr. Crutcher decided to operate, and in doing so he came upon an ovarian cyst, which was duly removed. After an uneventful recovery a period of two years' good health followed, but 1898 found her with another growth in the pelvis. Operation was deferred, as Dr. Crutcher was unwilling to interfere if he could avoid doing so, but the growth increased in size, and laparotomy was performed once more. Two large intra-ligamentous cysts filled the pelvis, each containing forty ounces of fluid, the contents of the left cyst being almost black, those of the right clear and limpid. The cyst-walls were stitched to the peritoneum, and

the cavities packed with gauze. They both closed in a short time. Mrs. B.'s final appearance in Dr. Crutcher's consulting-room was occasioned by another ventral hernia, but, as we have already said, he declined to operate again. The last news that came to hand with regard to her was that she was being cured by the faith-healers.

#### The Functions of the Dental Pulp.

A WIDER knowledge of the extreme delicacy of construction of every part of the body subserving a special purpose would undoubtedly tend to prevent its abuse or neglect. The intricacy of the visual mechanism and the consequences of overstrain are quickly appreciated by the public, but when it comes to the teeth they are simply regarded as bits of bone, able to stand an unlimited amount of wear and tear. The dental pulp itself, with its wonderful fibrils, is at least as delicately fashioned as the retina, though it may not be such a highly specialised tissue. The vital action of this vascular and sensitive substance is by no means sufficiently recognised. Dr. R. R. Andrews, in a paper read before the fifty-fifth Annual Session of the American Medical Association, in the Section of Stomatology, laid particular stress upon the truly vital functions of the dental pulp, the chief of which is the protective influence exerted upon the dentine. By virtue of its odontoblasts, the cells nearest the surface, any weak place in the dentine is speedily repaired, and, indeed, attempts at calcification may be seen under the microscope throughout the whole of the superficial layer. Its great vascularity and the thinness of the walls of the blood-vessels suggest that the leucocytes play an important part in the absorption and destruction of deleterious substances. When the tooth is allowed to decay the vital action of its pulp is then overwhelmed, and it is a well-known clinical fact that the tubercle bacillus may find an entrance into the body through the channel of a carious tooth. The restoration of function of the dental pulp, in other words, conservative dentistry in the highest sense, is the whole aim and object of odontological science. *Conserve quam extrahere.*

#### The Fate of Biliary Calculi.

ONE of the most fascinating chapters in medicine is that which deals with the formation and destiny of the various calculi that are met with in the different organs, glands and ducts of the body. Their origin is frequently shrouded in obscurity, and the complications to which they may give rise are both numerous and sometimes puzzling. Thus, no less than twenty-three possible complications of gall-stones have been described, many of which are absolutely fatal unless the condition be promptly recognised and an immediate operation performed. The relative merits of medical and surgical treatment in cases of cholelithiasis has long proved a favourite theme for discussion at the learned societies, and there can be no doubt that the former method is of great value as a prophylactic. If the formation of calculi can be prevented altogether, so much the better, but when once they are present:

the individual is not free from danger until they have either been removed by operation or passed *per vias naturales*. The most common complication of gall-stones is their impaction within the bile or cystic ducts, perforation of which not infrequently occurs. The fate of a moderately large biliary calculus is interesting to trace. Intestinal obstruction, ulceration, or perforation may occur as the result of a fistulous communication between the gall-bladder and bile-duct and the duodenum. The virulence and activity of the bacillus coli is apt to be much increased under such circumstances, so that septic changes involving the mucous membrane of the passages traversed by the stone may arise. One of the most remarkable complications is the elimination of the calculus directly through the skin of the abdomen, which cannot be regarded as a common event. M. Princeteau (a) has recorded the case of a woman, æt. 59, in which a good-sized gall-stone was ejected spontaneously through the right hypochondrium, a minute sinus having previously existed at the spot.

#### Shakespeare's Grave.

It would be difficult to match the so-called Shakespeare-Bacon controversy in any age of which we have record. If ever an example were needed to illustrate the hold that ingenious sophists can obtain over thoughtful, well-educated minds, the wrangle over the personality of the author of Shakespeare's works would surely furnish one of the most remarkable. When people seriously set themselves to work on iconoclasm, and are prepared to admit evidence of any kind, astonishing results can be obtained. A well-known playwright of his day, whose personality and productions were as well known to his contemporaries as those of Mr. Pinero and Mr. H. A. Jones to us to-day, has been conclusively shown by different parties—(a) to have been somebody else; (b) to have been two people; and (c) not to have existed at all (as an author). Those who are old-fashioned enough to enjoy the greatest dramatic masterpieces of any time, and credulous enough to attribute their authorship to the man who wrote them, stand aghast at the latest proposals of the fanatics, for they are little else, who wish to open the poet's tomb in search of confirmation for their fads. What good could possibly result from such a procedure it is impossible to conceive. Knowledge of personal appearance of Shakespeare is derived principally from the famous "Droeshout" paintings and the bust in Stratford church; each is inartistic, and probably fanciful. They differ greatly the one from the other; indeed, their chief points of resemblance are the fulness of the hair over the ears and the baldness of the crown of the head. All the other portraits are of doubtful authenticity, and even more widely divergent. After a lapse of three hundred years one could not hope to discover from a grave seventeen feet deep any remains that could possibly lead to identification. The cause of science or of justice may occasionally de-

mand the exhumation of a body, but it is sheer stupidity to expect than any useful information could be derived from desecrating Shakespeare's grave. We would be inclined to associate ourselves with the primitive curse contained in the doggerel inscription over the dramatist's tomb on those who wish to disturb his bones.

#### The Sense of Smell.

In civilised man the sense of smell is a faculty undoubtedly much less developed than among his primitive ancestors; indeed, there is anatomical evidence that the olfactory lobe is but a remnant of what it has been in lower animal forms. To those addicted to travel on the Continent this state of things may be advantageous, but there is no doubt that in medicine the sense is often one of great value. Typhus has a characteristic odour, which to those accustomed to deal with the disease is of itself sufficient to establish a diagnosis, and to some, indeed, even typhoid is recognisable on like grounds. Persons suffering from tuberculosis of the lungs are perceived by their attendants to have a stale, sour odour about their bodies, probably from decomposition of sweat, and most doctors and nurses are acquainted with the acid smell of patients with acute rheumatism. These are only some diseases among many in which the nose is a useful aid to diagnosis, and in chemical tests and pathological observation the olfactory sense is often of no little help. The sense of smell can be cultivated, and to medical men may be commended the olfactory exercise which serves the Japanese not only with a means of educating a neglected faculty, but with a pleasant pastime. "Incense snuffing," as it is called, is a ceremonial that has been in vogue for four centuries in the land of the chrysanthemum, and the rules of the game have been elaborated in weighty treatises. The principle on which it is founded is that of competition. The host of the *kiki-ko* party brings in a tray covered with different kinds of incense, to each of which names or numbers are given. These varieties of incense are then burned alone and in combination, and the guest who identifies the largest number by their smell is awarded a prize. An interesting point is that between the smells the competitors are provided with vinegar to sniff, in order to bring the Schneiderian membrane into working order again. By such an education the olfactory acuity of the Japanese is said to increase wonderfully. Perhaps the General Medical Council may see its way to add a course of sniffing to the list of obligatory studies in the medical students' curriculum.

#### The Diagnostic Value of the Strawberry Tongue.

THE anxiety with which the tongue is regarded by the physician in a suspected case of scarlet fever is in itself a sufficient indication of its diagnostic importance. As we all know, a thick white fur speedily develops upon the surface of the tongue through which some of the fungiform papillæ may generally be seen protruding. In three or four days

(a) *La Médecine Moderne*, August 10th, 1904.



this coating disappears, leaving a raw surface studded with injected and enlarged papillæ. The appearance of a ripe strawberry is by this time fairly well imitated. Dr. Foord Caiger states that a renewal of the normal epithelium occurs early in the course of the second week of the disease, when the tongue assumes its usual aspect. In common with most physical signs, however, a too absolute reliance cannot be placed upon the "strawberry tongue," for, according to Dr. J. F. Schamberg, (a) this sign is not present in every case of scarlet fever, indeed, in mild cases the tongue may appear quite normal. Redness of the tip and edges, the remainder being coated with fur, is by no means characteristic of scarlatina alone, for a somewhat similar appearance may be observed in typhoid fever. Again, mere enlargement of the papillæ occurs in some varieties of superficial glossitis, in which the resemblance in question is only a distant one. The healthy tongue may also exhibit considerable variation from time to time in the size of its papillæ, according to the degree of congestion and activity of the mucous membrane of this portion of the alimentary canal. In erythema scarlatiniforme, a disease which, perhaps, simulates scarlet fever more closely than anything else, the "strawberry tongue" has been seen in its most typical form. The appearance of the tongue must therefore be taken in conjunction with other physical signs, such as the sore throat, the rash itself, and the constitutional symptoms, as an aid to diagnosis.

#### The Royal Commission on Extra-Asylum Lunacy.

A MUCH-NEEDED Royal Commission has been at length appointed to inquire into the existing methods of dealing with idiots and epileptics, and the imbecile, feeble-minded, or defective persons not certified under the Lunacy Laws, and to report as to the amendments in law or other measures which should be adopted in respect of their care, training, and control. The following have been appointed by His Majesty the King as members of the Commission:—The Marquis of Bath (Chairman), Mr. William Patrick Byrne, C.B., Dr. Frederick Needham, Mr. Henry David Greene, K.C., M.P., Mr. Charles E. H. Chadwyck-Healey, K.C., Rev. Harold Nelson Burden, Mr. Charles Stewart Loch, Mr. Charles Hobhouse, M.P., Mr. Willoughby H. Dickinson, and Mrs. Pinsent. While recognising the difficulties that inevitably surround the selection of suitable members for a Royal Commission of Inquiry, we cannot help regretting that the medical profession is so inadequately represented. Dr. Needham is, of course, a tower of strength in himself, but in a matter of the kind to be investigated he should have been strengthened by two or three of the most experienced asylum authorities obtainable in the United Kingdom. The proportion of lawyers to medical men on this Commission repeats the traditional legislative attitude with regard to mental disease—namely, law first and medical science afterwards—*magno intervallo*.

(a) *Journ. Amer. Med. Assoc.*, August 6th, 1904.

#### Smoking Without Harm.

FROM Germany comes good news—it is possible to smoke without risk, if proper precautions are taken. Bamberger, who writes on the subject, divides consumers of tobacco into two classes—the dry smokers and the wet smokers. The former consist of those who puff their cigars through mouthpieces, and thus keep the ends dry. It includes also those who prefer the domestic pipe to the allurements of more costly methods of destroying tobacco. Wet smokers are those who chew their cigar ends or keep them constantly moist with saliva. These careless individuals have the mouth constantly filled with saliva in which the tobacco extracts are dissolved, and now that the spitting habit is forbidden they are forced to swallow quantities of this noisome juice. Consequently they suffer far more from the evil effects of tobacco than their "dry" brethren, and if in addition the "wet" smoker is addicted to alcohol his condition is a parlous one indeed. Bamberger would have medical men warn their patients to take to dry methods of smoking, and he suggests that in the stem of the cigar-holder a piece of cotton saturated with perchloride of iron should be placed, as thereby many harmful products of tobacco-smoke are rendered innocuous. It is, however, one thing for the physician to advise and another for the patient to follow the advice. To pack one's cigar-holder with wool would make smoking such hard labour that most men would prefer to forego the pleasure, whilst we fear that the admirable qualities of perchloride of iron do not include that of enhancing the flavour of the finest Havannas. A mouthful of "juice" from a pipe or cigar-holder is sufficiently distasteful without adding thereto the astringent properties of "steel drops." After all, our German friend comes late into the field, for the plan of filtering cigar smoke through a pledget of cotton-wool is as old as the hills. If the wool be lightly packed it may be not intolerable to the inveterate cigar-smoker—poor man!—who has been constrained to cut down his daily allowance—may we say a second time?—poor man!

#### Poplar Workhouse Scandal.

POPLAR Workhouse has long earned an unenviable reputation on account of the maladministration of its lunacy wards. Time after time in the columns of THE MEDICAL PRESS AND CIRCULAR have we called attention to the revelations of incompetency and inadequacy made at inquests. Again and again have we called for a Local Government Board inquiry into the administration of Poplar Workhouse Infirmary, especially as to the quality of the sick nursing and of the attendance and management of the lunatic ward. The latest inquest at Poplar Workhouse shows a laxity of administration that would not be tolerated by public opinion anywhere outside great, overgrown, callous London. From the evidence given before the Coroner on September 3rd, it seems that a paralysed man of thirty-seven was set to clean windows. He fell from some steps, became unconscious,

and was forthwith taken to the padded room and given a dose of salts by an attendant. Death was certified to be due to rupture of a blood-vessel in the brain. This picture is surely painful enough to attract the attention of the Local Government Board. First a partially disabled inmate is put to dangerous and absolutely unsuitable work. He receives a fatal head injury, and while unconscious is carried not to a ward but to a padded room, and salts are administered to him by an attendant. We should like to know by whose orders he was (1) set to window cleaning; (2) taken to a padded room; (3) dosed with salts. What have the Inspectors of that Board to say about the padded room and the single attendant in the lunatic ward? These facts have been brought to their notice by former inquests. In the public interest an accurate list of inquests held in Poplar Workhouse and resulting in censure by juries would be of advantage. Meanwhile, a searching Local Government Board inquiry is, in our opinion, imperative.

## PERSONAL.

THE King has presented his Marienbad physician, Dr. Ott, with a coloured portrait of himself in the uniform of an Austrian General.

SIR RENNELL RODD'S probable succession to the Embassy at Rome has recalled his mission to King Menelik of Abyssinia in the Diamond Jubilee year. The average height of the members of that mission was well over six feet, and that of Dr. Pinchin, the medical officer, was no less than six feet seven inches, while two others reached six feet four inches.

DR. HEGER was President of the International Congress of Physiologists held at Brussels last week, in the absence of Sir Michael Foster, M.P.

DR. G. B. MASON has been gazetted Surgeon-Lieutenant of the Mounted Infantry Company of the Antigua Defence Force.

It is officially announced that Dr. S. J. Steward has been appointed a supernumerary Government Medical Officer of Trinidad, West Indies.

DR. J. A. PICKELS, Medical Officer of Lagos, has arrived in England on leave of absence.

CAPT. A. E. HAMERTON, R.A.M.C., and Capt. C. Hudson, I.M.S., are mentioned in dispatches from Somaliland as having done particularly valuable work.

THE Principal Medical Officer has also brought to notice the merits of Capt. S. de C. O'Grady, R.A.M.C., Capt. F. L. Blenkinsop, I.M.S., and Major F. W. Gee, I.M.S., who are accordingly mentioned in the Somaliland dispatches.

AMONG non-commissioned officers appears the name of Corporal D. Watt, R.A.M.C.

ON the 2nd instant, Miss Blanche Julia Cripps, elder daughter of the well-known surgeon, Mr. William Harrison Cripps, F.R.C.S., of 2, Stratford Place, London, W., and Abbotsford, N.B., was married to Mr. T. Jefferson Faulder, house surgeon at St. Bartholomew's Hospital.

THE Winter Session of Charing Cross Hospital Medical School will commence on Monday, October 3rd, by the delivery of the fifth Biennial Huxley Lecture by Sir William MacEwen, F.R.S., and the Old Students

Dinner will be held on the same evening at the Hotel Métropole.

SIR THOMAS STEVENSON will open the Winter Session of Guy's Hospital Medical School on Monday, October 3rd. A House Dinner will be held the same evening in the College Dining Hall at 7.30 p.m.

THE Winter Session at King's College, London, will begin on Tuesday, October 4th, with an introductory address at 3.30 p.m. by Dr. Thomas Buzzard. In the evening the Old Students' Dinner will be held at the Hotel Cecil at 7 p.m., Dr. Urban Pritchard in the chair.

DR. PERCY KIDD will take the chair at the annual dinner of the London Hospital Medical School, in the College Library, on October 3rd, at 6.30 for 7 p.m., the Winter Session opening the same day.

AT St. Mary's Hospital Medical School the Winter Session will begin on Monday, October 3rd, with an introductory address by Dr. A. E. Wright. The annual dinner will be held at the Whitehall Rooms, Hotel Métropole, on the same evening, Mr. A. Q. Silcock in the chair.

THE annual dinner of past and present students of the Middlesex Hospital will take place on October 3rd, at 7 o'clock, at the Trocadero Restaurant, Dr. Sidney Coupland in the chair. The Winter Session will open on the same date.

THE Winter Session of the Medical Faculty of University College, London, will commence on Monday, October 3rd, with an introductory lecture by Professor J. Norman Collie, Ph.D., F.R.S. The Old Students' Dinner will be held the same evening, at the Hotel Cecil, when the chair will be taken by Mr. John Tweedy, President of the Royal College of Surgeons.

WESTMINSTER HOSPITAL MEDICAL SCHOOL will open on Monday, October 3rd. The annual dinner will take place on the same evening at the Trocadero Restaurant, when the chair will be taken by Dr. W. Rivers Pollock.

ARTHUR THOMSON, M.A.Oxon., M.B.Edin., Professor of Human Anatomy and Regius Professor of Medicine, has been elected a member of the General Medical Council for a period of five years.

SIR ISAMBARD OWEN has been appointed a Governor of the Welsh University of Aberystwyth.

It is announced that Dr. Jameson will return shortly to the Cape, although he has not regained his usual state of health.

DR. FREDERICK NEEDHAM, Commissioner in Lunacy, and ex-President of the Medico-Psychological Association, has been appointed a member of the Royal Commission of Inquiry into existing methods of treating persons of defective mind not certified under the Lunacy Laws.

DR. OTT has been authorised to make the following statement to Reuter's representative regarding his Majesty's cure:—"The King has obtained this year excellent results from his visit and cure in Marienbad. While his Majesty had come in very good health, the cure has had very beneficial effects, and the King leaves Marienbad in the most perfect health in every respect, and declares that he never felt better in his life. The waters, the baths, the exercise, and the diet have agreed wonderfully well with his Majesty, and his sleep is as sound as possible. The King has lost just the proper amount of weight, a fact which is clearly evident in his light and easy step. His Majesty will undergo a slight after-cure for ten days or a fortnight, consisting merely in taking a small quantity

of Marienbad salts. His Majesty has expressed his entire satisfaction with the results of his cure at Marienbad."

### Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENTS.]

#### SCOTLAND.

STATE REGISTRATION OF NURSES.—Miss Isla Stewart, Matron of St. Bartholomew's Hospital, delivered an address on this topic in Edinburgh last week. She said that the prevailing state of affairs was unfair to the public, and also to the trained nurses who had to compete with the half-trained. Two Bills for the registration of nurses were at present before Parliament—one by the State solely for the registration of nurses, and the other by the Royal British Nursing Association. Both Bills provide for a Central Council, whose importance could not be over estimated. In the former Bill the Council would be composed chiefly of nurses elected by and responsible to the body of nurses whom they represented. The institution of public examinations, and the granting of certificates to successful candidates would ensure a minimum standard of technical efficiency. Power was also given to the Council to remove the names of nurses who prove unworthy from the Register. This is the first time that the subject of registration of nurses has been brought prominently before the notice of the public in Scotland, and it cannot be said that hitherto the profession have displayed any great interest in the matter. The meeting was not largely attended, and few of the general public or medical profession were present—to some extent, no doubt, owing to the comparative emptiness of the city at the holiday season.

#### BELFAST.

THE DISTRICT LUNATIC ASYLUM.—The annual report of this institution, just issued by the medical superintendent, Dr. W. Graham, contains a number of matters of interest. The average daily number of patients under treatment was 1,021, and the admissions during the year were 254, a reduction of 13 as compared with the previous year. The cost of provisions was £8 9s. 9d. per head, and the total cost £23 9s. 10d. per head. After deducting receipts from pay patients, profits from the farm, and Government grants, the cost to the city is £13 14s. 5d. per head. Of the 254 cases admitted, hereditary influence is assigned as the probable cause in 29, but, as Dr. Graham points out, these figures are not worth much when we consider the well-known reluctance of families to admit such a cause. As one of the contributory causes to the recent increase in the number of cases, Dr. Graham lays some stress on changes in the dietary of the people. As he says, the labourer and artisan used to make porridge, milk, and potatoes, with an occasional piece of fish, their staple food. Now they use quantities of Indian tea (which they often boil), and stout, and all sorts of cheap tinned foods.

The most remarkable point is the increase of general paralysis of the insane—18 males and one female having been admitted during the year. In the four years 1894-97 there were nine cases admitted, and in the same number of years 1900-03 there were 57 admissions suffering from this disease. Taking this as his text, Dr. Graham gives a very vigorous little sermon on the necessity which he thinks exists for better teaching in matters of morals and hygiene.

THE SMALL-POX OUTBREAK.—A few fresh cases continue to crop up each week in various parts of Ulster, though as a whole the outbreak is certainly dying out. One case was discovered in Belfast last week, and removed to the hospital at Purdysburn. A bad case was admitted to the fever hospital at Irvestown, co. Fermanagh, and died in a few days. Practically all the inhabitants have been re-vaccinated. One case was admitted to Clones fever hospital

last week, and there, too, re-vaccination is general. There are five cases in Cavan fever hospital.

CHAIR OF PATHOLOGY IN QUEEN'S COLLEGE, BELFAST.—A petition has been drawn up and circulated for signature among the members of the hospital staffs in Belfast, in favour of the candidature of Dr. Thomas Houston for this chair. This petition is addressed to the President of Queen's College, and as it has been signed by practically every hospital man in the city, it can hardly fail to carry weight. As has been pointed out, the Chair of Pathology differs from all other chairs in this, that it is a matter of direct moment to the members of the medical profession in the district as to who its occupant is, for they must come into almost daily relation with him in making pathological examinations. Dr. Houston is a man so thoroughly qualified to fill the vacant chair, and such a favourite with the profession generally that the feeling in his favour is very strong. For the purely scientific chairs much may be said for appointing the best-qualified man without respect to local feeling, but in a chair whose occupant is in such intimate relations with the local men in practical work it is felt that a well-qualified local candidate deserves special consideration.

### Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Taylor answers, in your last issue, not my letter of August 10th, but my case as pressed on his consideration by "Qualified Assistant." What answer has he given to my query whether, I, a struggling country practitioner, being married, ought to bring into the world an unlimited family? In the most pleasant but 'evasive way Dr. Taylor intimates he has not sufficient grounds to say if I was justified in getting married. That is not the point. Rightly or wrongly, I am married (to a charming gentlewoman, by the way). Ought I to follow Dr. Taylor's proposition and thereby court inevitable starvation in our small home? His general law applies to all married folk, and must, if true, be of universal application. Therefore, I ask Dr. Taylor once more if, with the income of a well-to-do artisan, but with the necessary outward show of a well-to-do member of the middle classes, I am morally constrained to produce an unlimited progeny? Finally, is continence—the highest form of restriction—to be banned as well as methods or artificial prevention? A writer who lays down the law in so decisive a way as Dr. Taylor can surely explain details of application.

I am, Sir, yours truly,

A COUNTRY PRACTITIONER.

Bucks, September 1st, 1904.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I must express my cordial thanks to Dr. Taylor for his courteous reply to my letter; I am much indebted to him for so kindly dealing with the specific points I raised. But I cannot say that to my mind the difficulty is solved. In the first place I think it is a pity Dr. Taylor avoided a direct reply to the question whether our friends the country doctor and the poor curate did right to marry. No doubt there were many factors to be considered in their cases, but I hoped the issue would be narrowed down to the single point whether a professional man with an income of say, £150 or £200 a year profit, little reasonable prospect of increase, and no expectations should consider himself debarred from the comfort that a good wife would bring to his home, because he absolutely could not afford an unlimited family. Our country practitioner is, let us assume, a well-educated man, pursuing a life of hardship and self-sacrifice for the benefit of his fellow creatures. His home is his only pleasure. Is he to have what every labourer in the country looks to have—a help-

meet and stay, or to be dependent on the caprices of some elderly village body who will come in and "do for" him? And our poor curate, without the least disparagement to him, I can only say that perhaps the greatest benefit of the Reformation lay in abolishing celibacy for the clergy. Dr. Taylor will appreciate what I mean.

"Two wrongs will not make a right." Paraphrased this means—Because society forbids you to be natural, you are wrong in being unnatural. It is a choice of unnaturalnesses. The sexual instinct is natural; you must either abstain, which is unnatural, or take artificial precautions, which is unnatural. You are in a dilemma. The only way out is to marry and abstain, which is probably the most unnatural, as well as the most impracticable.

To young men like myself who look forward to an opening in the near future, bachelorhood is regarded merely as a temporary penalty that one pays for having been born in a certain social stratum, but one cannot be blind to the fact that some day the question of providing for more children than one can afford may present itself in concrete form. I cannot hope that Dr. Taylor's practical philanthropist will have put the world into joint by that time, and I fear it will be but cold comfort I should derive from contemplating how much longer it would be before the hardness of my lot forced an alteration in the economic conditions of the country. All of us have not a Horace's capacity for suiting circumstances to ourselves, and are compelled to suit ourselves to circumstances.

I am, Sir, yours truly,  
QUALIFIED ASSISTANT.

Glasgow, September 3rd, 1904.

#### THE LUNACY QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some years ago there was a discussion at one of the London Medical Societies which was rather amusing. I remember hearing the late Sir Wm. Gull assert that it was easier to calculate the distance between the sun and our earth than explain the phenomena of insanity; in fact, that it was a great deal more difficult to understand the aberrations of the brain than those which astronomy has to consider. Very few at first agreed with Sir William and the specialists in insanity did certainly not agree with him.

Sir William, however, had far the best of them in the discussion, and most of those who heard him came away with the impression that he was right in his views, and that insanity is an incomprehensible matter, and cannot be dealt with in the same way as most maladies of the human system.

To try and define insanity is like trying to define most negatives, and it would be well to define sanity first before dealing with the negative.

It would be well if a law were passed that practitioners should be required to report to some central authority all cases that they attend or advise upon, if in any such cases the mind of the patient is so disturbed or deranged as to require special care to be observed by those in charge of the case, lest any injury might be caused by the patient to himself or others in any way, or the patient might suffer from improper influence personally or in any other way, that is, in respect to disposal of property, &c., &c.

I hope that THE MEDICAL PRESS AND CIRCULAR will assist the Commission appointed to deal with this subject,

I am, Sir, yours truly,  
ROBERT J. LEE.

West Kensington, Sept 5th, 1904.

#### THE POSITION OF MEDICAL OFFICERS OF HEALTH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The *Times* has recently published an able and comprehensive account of the Report of the Committee on Physical Deterioration, and a leading article upon it. In this article the difficulty of the position of

medical officers of health is, among other things, discussed. The article points out that the provision of the Act of 1872, by which the post of medical officer of health is created, has been virtually neutralised in many places by the fact that the officer is the servant of a body of men, many of whom obtain seats upon local authorities with the purpose of placing difficulties in the way of active sanitary administration. Enforcement of sanitary laws is not compulsory, and the Local Government Board has no power to coerce the Authority. The medical officer may remonstrate in private when flagrant neglect of duty is displayed, but it is as much as his place is worth to make any public protest or to set himself in open antagonism to his employers. He knows very well that when the Authority is dominated by men of a certain type it is because there exists no public opinion to which an appeal can be effectually made, and that such an appeal would surely lead sooner or later to loss of his position. In most cases the officer, recognising that there is no remedy, is forced to restrict himself within a very limited sphere of activity, much as he may regret and deplore it. In many municipalities, especially in the smaller towns when tradesmen and owners of slum property dominate the Authority, the model bye-laws of the Local Government Board, although adopted in their entirety, are enforced only in so far as they do not interfere with the interests of landlords; the sanitary inspector's department is undermanned and unprovided with disinfecting or even drain-testing apparatus; slum dwellings, displaying all the worst forms of insanitary conditions and over-crowding, abound, whilst in many places no provision is made for isolation of any form of infectious disease, and the Food Adulteration Acts are simply ignored. As the *Times* points out, it is in boroughs where local administration presents this character that the inspectors of the Local Government Board are so often engaged in investigating the causes of outbreaks of disease, and where, after tracing this or that epidemic to its origin they as constantly report that the whole inquiry was but a repetition of one conducted in the same place a few years previously, and that the overcrowding, or the water contamination, or the slum dwellings, to which the attention of the locality was directed on the former occasion, have remained unaltered, if not aggravated by increase of population. Towards remedy of these abuses the Committee on Deterioration recommend that the post of medical officer of health should be made permanent, so that the officer should not be liable to dismissal by the Authority when striving to carry out his duty conscientiously. The *Times* seems to think that such a reform would put an end to the evils it exposes. It avows that modern sanitary legislation "has been practically inoperative in the very places in which it was most required, and has left large sections of the population to live and grow under every conceivable moral and physical disadvantage, while the ratepayers themselves are absolutely without any remedy against their 'representatives.'" No doubt some good would be done by giving the medical officer of health security in his position; but as the Authority would still fix the amount of his remuneration and control its increase when deserved, it is easy to see how uncomfortable the position of an uncompliant man might be made, and how far from independent he must remain. What is most remarkable is the *Times'* suggestion that the ratepayers have no remedy. Their remedy, and the only complete remedy for the abuses which exist more or less throughout the country, is to turn out inferior members of local authorities and replace them by men really imbued with public spirit and not capable of sacrificing the welfare of their poorer fellow-citizens in pursuit of selfish, mean, and sordid ends. This remedy is in the hands of the 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 to take any part in it; they will not offer themselves as candidates for local boards, nor take active steps in putting fit men on. Even in London not more than

40 per cent. of the burghesses could be induced to vote at the last County Council election, and there prevails an equal lack of local patriotism in this regard throughout the country. Democratic institutions cannot be administered to full advantage unless all intelligent citizens take a due interest in their working. The existing apathy forms a danger to the nation. Rather than allow the present state of things to continue, it would almost be better to revert to bureaucracy and put the whole of the sanitary administration of the nation into the hands of the Local Government Board. The proposed change in the status of the medical officer of health would be a move in that direction; but by diminishing the responsibility of the local authorities, and encouraging the indifference of responsible citizens whose duty it is to guard the interests of the community to which they belong, it would, it seems to me, do even more harm than good to the cause of real reform and advancement.

I am, Sir, yours truly,  
AN ACTIVE SANITARIAN.

### Obituary.

#### INSPECTOR-GENERAL OF FLEETS DUGALD MACEWAN, M.D., R.N.

WE regret to announce the death of Inspector-General Dugald MacEwan, M.D., R.N., at his residence in Bedford, at the age of seventy-eight years. Dr. MacEwan was a native of Lochgilphead, Argyllshire, and he entered the Royal Navy as Surgeon in 1847, became Staff Surgeon in April, 1856, Fleet Surgeon in 1875, Deputy Inspector-General of Hospitals and Fleets in January, 1882, and Inspector-General in January, 1887. He served in China, the East Indies, and Burma, in the Baltic throughout the Russian War, and was present at the bombardment of Sweaborg and Hango, in South America. His decorations included the Burmese and (Russian) Baltic medal, and the Jubilee and Coronation medals. He was awarded the "Sir Gilbert Blanc" medal, and was Honorary Physician to the King and to the late Queen Victoria. At the time of his retirement in 1887 he had for seventeen years been in attendance when her Majesty was travelling on board the Royal yacht, *Victoria and Albert*. He is survived by his widow, four sons, and three daughters.

#### SURGEON-MAJOR JOHN CAMPBELL, C.B., M.D., R.A.M.C.

SURGEON-MAJOR JOHN CAMPBELL, C.B., M.D., late Indian Army, who died on Friday last at Looe, Cornwall, was born in 1817. He was the youngest son of the late Captain Thomas Campbell, R.N., and served in the Afghan War of 1841, in Scinde in 1843, and in the Indian Mutiny in 1857. He was decorated for the services which he rendered during the siege of Lucknow.

### Literature.

#### TAYLOR ON APPLIED ANATOMY. (1)

MR. TAYLOR'S book is undoubtedly one of the most interesting works dealing with anatomy published within recent years. The plan of the book, which the author rightly describes in the preface as "*surgery from the anatomical standpoint*," is excellent. The arrangement of the material and the manner in which it is presented enables the reader to find in the shortest possible time the information which he seeks. The various regions of the body are each first dealt with in a short anatomical description—the more minute details being given in smaller type—and then the bearing of a knowledge of the anatomical facts upon the pathology of the part, and upon the diagnosis and treatment of its morbid conditions, is graphically explained.

This method of presenting anatomical facts and details is undoubtedly one which will excite and hold the interest of the reader.

(1) "A Treatise on Applied Anatomy." By Edward H. Taylor, M.D., F.R.C.S. L., Surgeon to Sir P. Dun's Hospital, Dublin; Examiner in Applied Anatomy, Trinity College, Dublin. Pp. xxvii and 788. With 178 figures and plates, many in colours. London: Charles Griffin and Co. 1904.

The importance of an accurate knowledge of anatomy in surgical work can hardly be over-estimated, and since it is not merely a knowledge of isolated applied facts which is essential, we feel that the author has done well in introducing into his descriptions an accuracy and an amount of anatomical detail often found lacking in works on applied anatomy. In the progress of medicine, surgery and pathology anatomical and embryological observations and discoveries, at first merely of scientific interest, are ever proving themselves of the greatest importance in elucidating and explaining morbid conditions, or in enabling physicians and surgeons to arrive at correct diagnoses and devise new forms of treatment. It is indeed quite useless to attempt sharply to separate the points which are of practical from those of pure theoretical importance in anatomy. The subject is, however, so vast that all parts cannot be treated equally, and selection is, therefore, necessary. We believe that in making his selection Mr. Taylor has been most successful, and that he has produced a work which will be not only of the greatest use to surgeons, but will also prove itself a stimulus to students of anatomy by indicating to them the manner in which a knowledge of this subject is of the highest importance in explaining and elucidating the subjects studied in the later years of the medical curriculum.

In a short notice it would be quite impossible to call attention to the many excellent points presented by the work, but we must not fail to mention the many beautiful illustrations drawn from specially prepared dissections. These are the work of Mr. J. Murray, and are a special feature of the book—indeed, many of them are among the most beautiful anatomical pictures that we know.

Perhaps the most interesting of these figures are those illustrating the relationships of the parts connected with the organ of hearing to the base of the skull, those exhibiting the firm connections and relations of the stomach, and those dealing with the surgery of the rectum.

The general impression left by a survey of Mr. Taylor's book is that it is the right kind of work to place in the hands of the best type of medical student in his final years.

#### BISHOP ON ESSENTIALS OF PELVIC DIAGNOSIS. (a)

THE design of this book is to assist those who have little practical acquaintance with pelvic diagnosis, but whose general training is such as enables them to pick out the salient symptoms of a particular case. Elaborate tables, evidently very carefully considered, have been constructed with the object of conducting the inquirer along settled routes to a definite opinion as to the true nature of the disease which lies at the root of these overt symptoms and signs.

In a fair preface there is, what seems to us, a just appreciation both of the difficulties, dangers, and objections to the making of such a book. We quite agree that as to the value of such each one must judge for himself. But it is undeniable that such a book as this presupposes the existence of very grave gaps in clinical education—of lacunæ which, if often found, could hardly be filled in or bridged by the most elaborately compiled tables. Indeed, while we admire the completeness of these "aids to diagnosis," we question whether their very accuracy and completeness would not prove the most effectual bar to their usefulness. Assuredly, the average text-book would better serve the wants of the average man. The main objection would seem to lie in the very difficulty of utilising the methods. Those who most require assistance are exactly those least fitted to avail themselves of so complex a scheme. We incline to believe that this book will be most liked where least needed.

(a) "The Essentials of Pelvic Diagnosis, with Illustrative Cases." By E. Stanmore Bishop, F.R.C.S., Hon. Surgeon, Ancoats Hospital, Manchester, &c.; and an Appendix on Examination of the Blood, &c. By C. H. Melland, M.D., Hon. Physician, Ancoats Hospital, Bristol; John Wright and Co. London: Simpkin, Marshall, and Co., Ltd.

Perhaps the foregoing general observations do scant justice to the plan of the work. Properly to understand this the Introductory Chapters should be read. These are followed by a few chapters on general methods of examination, these by a particularly interesting discussion of pain as a diagnostic factor in pelvic disease.

The Appendix (Examination of Blood) seems a somewhat needless addition to the work.

#### GALABIN ON DISEASES OF WOMEN. (a)

THE sixth edition of this well-known manual, which we have often favourably noticed in its earlier editions, hardly calls for detailed criticism.

Most of the new material concerns operative technique, and a notable addition and improvement is to be found in Chapter 14, which is devoted to Diseases of the Urethra and Bladder. Such a chapter is indeed inevitably needed in any modern work upon gynaecology.

There are many new illustrations, though we cannot specially commend the illustrations as a whole. The micro-photographs, also a new feature, and twenty-five in number, might in the greater number of cases have been omitted. Take, for example, Fig. 82, which purports to show in section the mucous membrane of a uterus removed by hysterectomy on the first day of menstruation. But there is here no emphasis of the characteristic details—only just enough for a specialist to rely upon. Why not append a description to each micro-photograph which would draw attention to noteworthy points; and why not also give—as is done in some cases—the magnification, or still better a statement of the glasses—eye-pieces and objectives—used. The popularity of the book has been proved and is deserved. It is essentially practical in its scope; and its teaching is clear and unambiguous.

#### CRILE ON BLOOD PRESSURE IN SURGERY. (b)

IT is a considerable time since we have read a work of such interest and of so great practical importance as is the volume before us, containing the account of the researches made by Dr. Crile into causes of altered blood pressure and the deductions which he has been able to draw from these researches. We may say at once that the work he has done appears to us to be of the very greatest value, and to have well deserved the Cartwright Prize which it obtained.

The first 260 pages of the book are occupied by the statistics of 251 experiments made on animals. There is, of course, in this part, a large amount of repetition, but as the experiments were most costly in time and trouble, it was considered well to have a full account of them placed on record. The last 150 pages are occupied with the summary of experimental data, and are of the greatest interest; but even if the busy surgeon has not the time necessary for their close study he will find an admirable *résumé* of Dr. Crile's conclusions in the last ten pages. Dr. Crile recognises that there are two different causes of death during surgical procedures—shock and collapse. Shock is an exhaustion of the vaso-motor centres, in which neither the heart-muscle, the cardiac centres, nor the respiration are other than secondarily affected. Collapse is due to a suspension of the function of the cardiac or of the vaso-motor mechanism, or to hæmorrhage. In the former, the exhaustion of the centres renders stimulants and strychnine of little value; indeed, the latter is, in the writer's opinion, dangerous. Saline infusion is also of slight or no use. On the other hand, adrenalin acts on the heart and the blood-vessels, and raises the blood pressure in every degree of shock, even when the medulla has been cocaineised and in the decapitated animal. It is, however, rapidly oxidised by the tissues and blood, and its effects are fleeting. It consequently must be given continuously, but also

with caution, as it possesses a power of markedly stimulating the cardio-inhibitory mechanism. In collapse, cardiac stimulants and strychnine are both of value as the vaso-motor centres are not exhausted. Saline infusion was also found to be of value. In shock, a contrivance called the pneumatic rubber suit, made with the object of providing an artificial peripheral resistance and so raising the blood pressure, acted successfully. By the combined use of artificial respiration, the infusion of adrenalin, and the application of the rubber suit, a patient who, from fatal injury to the brain, had been conventionally dead for nine minutes, was partially resuscitated for thirty-two minutes, during which time a strong heart beat was noted, and he was able to move his head. We strongly recommend the perusal of this work to our readers.

#### PHYSIOLOGY OF DIGESTION AND DIETETICS. a

THIS privately published but most interesting volume consists of a series of reprints of essays which, during the last nine years, Dr. Robertson has contributed to various journals. They deal principally with the digestion and value of saccharine foods in health and disease, and should prove of interest to the physiologist and of service to clinicians.

### Literary Notes and Gossip.

THE forthcoming publishing season promises to be unusually prolific in new medical books and new editions; it is currently reported that one London house alone has as many as thirty in the press.

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A "HOSPITAL Penny Fund," has been inaugurated by the Editor of our interesting weekly contemporary *Public Opinion*. In his forcible appeal for funds he remarks that the Hospital Sunday and Saturday Funds are but annual affairs, and the man in the street—too often, alas!—thinks he has done his duty if he increases his offering to the collection on that Sunday, or, perchance, puts a piece of silver in the box of the Saturday Fund collector. Correct statistics of those who do and do not give are, of course, difficult of attainment, but the Editor avers that there are 30,000,000 in Great Britain who never give one penny. If each of these gave but a penny, over £130,000 would be realised. The scheme is not to be confined to London alone; but will appeal to the provinces, to Scotland, Ireland, and Wales, and incentives to collection will be offered in the shape of prizes. This philanthropic effort has our heartiest wishes for success.

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DR. H. C. L. MORRIS has written a serviceable little book on "Bognor as a Health Resort."

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DR. R. HENSLÖWE WELLINGTON, Secretary of the Medico-Legal Society has just published a valuable monograph on "The Verdict of Suicide whilst Temporarily Insane."

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WE understand that Dr. Norman Moore is writing a history of St. Bartholomew's Hospital, which will shortly be issued by Messrs. Arthur Pearson & Co. Mr. Howard Penton has drawn some original illustrations for the book, which will also include reproductions of the ancient seals and monuments of the Hospital with many historical reminiscences. The proceeds of the sale of the work will be devoted to the rebuilding fund, and the list of subscribers to the first edition, limited to two thousand copies, will be printed as an appendix. Applications for copies should be addressed to the Honorary Secretary of the Rebuilding Fund, St. Bartholomew's Hospital, London.

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WE have received from Messrs. Mabie, Todd and Bard publishers, and manufacturers of the famous "Swan" Fountain Pens, a well-printed

(a) "Diseases of Women." By A. L. Galabin, M.D., F.R.C.P., late Fellow of Trinity College, Cambridge; Consulting Obstetric Physician, Guy's Hospital, &c. Sixth Edition, much enlarged. London: J. and A. Churchill, 1903.

(b) "Blood Pressure in Surgery. an Experimental and Clinical Research." By George W. Crile, A.M., M.D., Professor of Clinical Surgery, Western Reserve Medical College. London and Philadelphia: J. B. Lippincott and Co. 8vo, pp. 422. 1903.

(a) "Contributions to the Physiology of Digestion and Dietetics" By W. G. Aitchison Robertson, M.D., D.S.O., F.R.C.P.E., F.R.S.E. Edinburgh, 1903.



booklet of fifteen photographic views of the great International Exhibition now being held at St. Louis, which convey a striking impression of the immensity and beauty of the various structures. Messrs. Mabie, Todd, and Bard intimate that they will gladly send a copy of the book free to all readers mentioning this paper, who apply by post-card to them at 93, Cheapside, London, E.C., 95, Regent Street, London, W.; or 3, Exchange Street, Manchester.

WE learn from the editor in chief of the *Index Medicus* (second series), that a circular letter has been extensively distributed signed by the Directeur général de l'Institut de Bibliographie médicale de Paris, 93, Boulevard Saint Germain, in which it is stated that the *Index Medicus* ceased to appear after the issue of the number for January, 1904, and that its publication would probably not be resumed this year. This statement is incorrect, had the writer inquired of the Secretary of the Carnegie Institution, or of the Editor of the *Index Medicus*, he would have been saved making an unfounded and misleading assertion. Its origin is doubtless to be found in the fact that owing to "strikes" in the printing offices of Boston, in which city the journal is printed, the January number was delayed.

### Medical News.

#### Postal Workers' Sanatorium Scheme.

A RECENT conference of representatives of the different branches of the postal service was held in one of the committee-rooms at the General Post Office, London, to consider a proposal for providing sanatorium accommodation for postal employes by affiliation with the National Committee for the Establishment of Sanatoria for Workers Suffering from Tuberculosis. The chair was taken by Mr. J. Fitzgerald (treasurer of the Fawcett Association). Mr. C. H. Garland, in an explanatory statement, said it was proposed to elect a provisional committee to carry out the necessary preliminary arrangements in connection with the movement for securing a sufficient amount of accommodation in sanatoria for all the cases of consumption which were likely to occur among postal servants. The original idea was to establish a sanatorium for themselves exclusively. When, however, the project was launched for providing sanatorium accommodation for the whole of the workers of this country, it was thought desirable to associate themselves with it. The National Committee was formed under the auspices of the Hospital Saturday Fund, and its scheme would have the support of the working classes generally. By allying themselves with those identified with the wider movement they would have placed at their disposal a large amount of expert opinion and advice. The proposal of the National Committee was to erect a sanatorium by public subscriptions, and the beds were to be endowed by friendly societies, trade unions, and other organisations. The object of the postal movement was to create a fund in order to reserve for the use of postal employes in that sanatorium a certain number of beds. The Postmaster-General had practically given his consent to their scheme, which included a voluntary payment by members of the postal staffs of 2s. per annum. He was told by the chief medical officer of the Post Office that a subscription of 2s. a year would produce a sufficient sum to provide all the accommodation required for Post Office cases, and would probably leave a surplus to pay the travelling expenses of those coming from a distance. There was no intention on their part to appeal for subscriptions outside the postal staffs. There would be a public appeal made by the National Committee for funds with which to build the sanatorium. The beds would be under the control of the organisations which endowed them. He could not say definitely where the sanatorium would be erected, but negotiations were going on for the acquisition of a site about seventeen miles from Hastings. The more hopeful members of the National Committee considered that building operations would be started early next year, while others thought that they would

not be started till the middle of the year. The subscription of 2s. a year by postal workers would entitle them to accommodation at the sanatorium free of all charge, and in addition their sick pay would be continued for six months. After further discussion, a provisional committee was elected to carry out the necessary preliminary arrangements.

#### St. Thomas's Hospital House Appointments.

THE following have been appointed House Officers from yesterday (Tuesday), Sept. 6th.—*Resident House Physicians*: B. Higham, M.R.C.S., L.R.C.P.; W. Haward, M.B., B.S.Dur., M.R.C.S., L.R.C.P.; H. C. Lecky, M.A., M.B., B.Ch.Oxon. (extn.); C. H. Latham, M.R.C.S., L.R.C.P. (extn.). *House Physicians to Out-Patients*: A. G. Gibson, B.A., M.B., B.Ch.Oxon., B.Sc.Lond.; K. Takaki, M.R.C.S., L.R.C.P. *Resident House Surgeons*: H. S. Bennett, M.R.C.S., L.R.C.P.; N. C. Carver, B.A., B.C.Cantab., M.R.C.S., L.R.C.P.; A. C. Birt, M.R.C.S., L.R.C.P.; G. T. Birks, M.A., M.B., B.C.Cantab. *House Surgeons to Out-Patients*: 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.; *Obstetric House Physicians*: Senior, J. P. Hedley, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; Junior, H. I. Pinches, M.A., M.B., B.Cantab., M.R.C.S., L.R.C.P. *Ophthalmic House Surgeons*: Senior, H. S. Stannus, M.B., Lond., M.R.C.S., L.R.C.P. *Throat Department*: T. B. Henderson, M.A., M.B., B.Ch.Oxon. R. E. Whitting, B.A., B.C.Cantab. *Skin Department*: W. L. Harnett, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; F. M. Bulley, B.A.Cantab., M.R.C.S., L.R.C.P. *Ear Department*: T. Guthrie, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.

#### Idiots and Imbeciles.—A Royal Commission.

THE King has been pleased to appoint a Royal Commission to consider the existing methods of dealing with idiots and epileptics and with imbecile, feeble-minded or defective persons not certified under the Lunacy Laws, and to report as to the amendments in the law or other measures which should be adopted in respect of their care, training and control. The members of the commission are as follows: The Marquis of Bath (chairman); Mr. William Patrick Byrne, C.B.; Mr. Charles Hobhouse, M.P.; Dr. Frederick Needham; Mr. Henry David Greene, K.C., M.P. Mr. Charles E. H. Chadwyck-Heale, K.C.; Rev. Harold Nelson Burden; Mr. Willoughby H. Dickinson; Mr. Charles Stewart Loch; and Mrs. Pinsent. Dr. Needham is a Commissioner in Lunacy and an ex-president of the Medico-Psychological Association.

#### International Congress of Physiologists.

THE International Congress of Physiologists met on August 31st at the Solvay Institute in Brussels and will continue in a series of similar meetings to be held at Turin, Cambridge, Berne, and Basle. The President, Dr. Heger, in his opening address, expressed regret for the absence through reasons of health of the Honorary President, Sir Michael Foster, M.P. The proceedings of the congress are private.

#### Killed by Swallowing a Wasp.

A COACHMAN named Fisher, who worked for Mr. Compton Rickett, M.P. for Scarborough, has just died at his employer's country seat at East Hoathly, near Lewes, as the result of a wasp sting. He swallowed the insect with some beer, and his throat was so badly stung that he was suffocated.

#### Sanitary Institute.

THE thirty-eighth course of lectures and demonstrations for sanitary officers which will commence at the Sanitary Institute, Parke's Museum, London, on Monday, September 12th, will embrace lectures on Municipal Hygiene and on Meat and Food Inspection, including the taking of samples of water, food, and drugs for analysis, with practical demonstrations of meat inspection.

#### Liverpool Mortality.

THE death-rate in Liverpool, which for some weeks has been very high, reaching 39.2 per thousand per annum a fortnight ago, fell during the past week to 29 per thousand. The decrease is due to the cooler weather, and the consequent fall in diarrhoea mortality.

## 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.

### LIFE INSURANCE QUERY.

F.R.C.P. writes in answer to query as to the proposal for life insurance from "O.F." in our last week's issue:—"This life may be insurable at hazardous rates in some offices. In that case it would be well for the medical examiner to state the case most clearly to the office, and to suggest a limitation of period covered by insurance. The non-recovery of applicant's weight, together with the low specific gravity of the urine, render the life undesirable from the insurance point of view. If the low specific gravity is permanent the case should, in my opinion, be rejected on any terms—this I suggest as a general view on data so far as available.—

Dr. E. N. P.—Antipyrine is credited with powerful anti-galactagogue properties and is sometimes employed to arrest the lacteal secretion. Under these circumstances it is by no means improbable that the administration of large doses of this antipyretic in cases of mild puerperal infection may explain the sudden cessation of the secretion in your patient. At the same time it has to be borne in mind that the secretion often ceases spontaneously, especially when there has been fever. In any case the administration of drugs of this class in puerperal infections is of much less therapeutical importance than measures aimed at removing the source of the infection.

### THE PRESERVATION OF RUBBER CATHETERS.

To the Editor of THE MEDICAL PRESS AND OBITUARY.

Sir,—In reply to the letter of your correspondent with reference to the "preservation of Rubber Catheters," we do not find that a good quality Red Rubber Catheter becomes "sticky" and swells after so short a use unless same has been treated with grease or oil in the place of glycerine. If this is the case the evil may be remedied by washing in warm water and soda immediately after use.

London, E.C., Sept. 2, 1904.

S. MAW, SON & SONS.

Mr. S. E. ATKINSON.—The report reached us as we were at press. We hope to utilise it in an early number.

Mr. B. BART.—We have seen it stated that such is the case but we have had no direct or official intimation of the fact.

S. E. V.—The Transactions of a Medical Congress are, so to speak, public property, and it is open to anyone to make use of them for literary purposes though it is customary and desirable in so doing to give the source of the information in order that readers may, if so disposed, verify their references.

Dr. Ross.—No, it would be decidedly improper for your correspondent to consent to attend a patient whose acquaintance he had made as deputy for a sick *colleague*, at any rate in respect of the particular illness.

### THE FREEDOM OF THE SOCIETY OF APOTHECARIES OF LONDON.

By an announcement in another column it will be seen that the governing body propose to admit ten members of the medical profession already holding the L.S.A. Diploma, to the freedom of the Society which we understand includes also the freedom of the city of London. Full particulars may be obtained on application to Mr. A. Mowbray Upton, Clerk to the Society, Apothecaries Hall, London.

Dr. HULFIELD (Malta).—The English Authorities do not recognise French degrees in our colonies, although facilities are offered for passing the Final Examinations to those possessing the degrees of a known university in France.

Mr. WARSON.—The latest information is being collected concerning the various Educational Institutions and will be published in *resumes* in our next number, including the query put by you.

Dr. J. E. HARBURY.—Communication to hand is hereby acknowledged.

### Vacancies.

Down District Lunatic Asylum, Downpatrick.—Junior Male Assistant Medical Officer. Salary £100 per annum, with furnished apartments, board, washing fuel, light, and attendance. Applications to the Resident Medical Superintendent.

Cardiff Union.—Assistant Medical Officer. Salary £130 per annum, with rations, apartments, attendance, and washing. Applications to Arthur J. Harris, Clerk, Union Offices, Queen's Chambers, Cardiff.

Resident Medical Officer for the Sanatorium for Consumptives at Eastby, near Skipton. Salary £100 per annum, with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, 22 Manor Row, Bradford.

London Open-air Sanatorium, Pinewood, near Wokingham, Berks.—Resident Assistant Medical Officer. Salary £100 a year, with board. Applications to the Secretary, London Open-air Sanatorium, 20 Hanover Square, W.

Rotherham Hospital and Dispensary.—Senior House Surgeon. Salary £110 per annum, with rooms, commons, and washing. Applications to the Secretary, E. S. Baylis, 19 Moorgate Street, Rotherham.

Metropolitan Hospital.—Casualty Officer. Salary £150 per annum. Applications to Charles E. Byers, Secretary.

Brighton, Hove, and Preston Dispensary (Northern Branch).—House Surgeon. Salary £160 per annum, with furnished rooms, coal, gas, and attendance. Applications to C. Somers Clarke, Hon. Secretary, 115 Queen's Road, Brighton.

Bath Royal United Hospital.—House Surgeon. Salary £80 per annum, with board, lodging, and washing. Applications to J. M. Sheppard, Secretary.

Birmingham General Dispensary.—Resident Surgeon. Salary £170 per annum, with furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

Township of Toxteth Park.—Resident Medical Officer. Salary £100 per annum, with board, washing, and apartments. Applications to J. Moulding, Clerk to the Guardians, 15 High Park Street, Liverpool.

Cheltenham General Hospital.—Assistant House Surgeon. Salary £92 per annum, with board, lodging, and washing. Applications to the Honorary Secretary, General Hospital, Cheltenham.

## Appointments.

ATTWOOD, RICHARD D. M.R.C.S., L.R.C.P.Lond., Second Assistant Medical Officer at the Southwark Infirmary.

BROSTER, W. B., M.B., C.M.Edin., Medical Officer of the White Lead Works, Burry Port.

## Births.

O'BRIEN.—On August 29th, at 29 Merrion Square, North, Dublin, the wife of C. M. O'Brien, M.D., of a son.

## Marriages.

FAULDER—CRIPPS.—On September 2nd, at the Marylebone Parish Church, London, Thomas Jefferson Faulder, son of the late E. B. Faulder, of Thursty, Carlisle, to Blanche Julie, elder daughter of W. Harrison Cripps, F.R.C.S., of 2 Stratford Place, London, W., and Abbotsford, Melrose, N.B.

GARRISH—JUDGE.—On September 3rd, at St. Giles's Church, Camberwell, Harold John Garrish, eldest son of J. T. Garrish, of Grove Lane, Denmark Hill, to Ethel Maud, daughter of E. W. W. Judge of Camberwell.

GOULD—PAPE.—On September 3rd, at St. Thomas's Telford Avenue, Stratham Hill, Valentine E. J. Gould, of Llanelly, son of J. E. Gould, M.D., of Bolton, to Maude Mary, only daughter of Geo. Pape, of Thornton Avenue, Streatham Hill.

LEADING—RICHARD.—On August 24th, Robert Craike Leaning, M.B., B.S., second son of the late Harry Leaning, Esq., of Chantry, Colchester, to Mary Gladys, youngest daughter of the late William Richards, Esq., of Talyceod, Monmouthshire.

WILSON—GRATTAN.—On Sept. 1st, Geoffrey Remington Wilson, M.A., M.B.Cantab., eldest son of Mr. Thomas Wilson, of Harpenden, Herts., to Eileen Margaret Georgina Grattan, youngest daughter of Dr. M. H. Grattan, of Ongar.

## Deaths.

BENNETT.—On September 2nd, at Amersham, Bucks, Ellen Selte Bennett, of 3 Marlborough Place, N.W., youngest daughter of the late Rev. Henry Page, and widow of the late Sir J. Eason Bennett, M.D., F.R.C.P.Lond., LL.D., F.R.S.

BURTON.—On September 2nd, at Southsea, Annie Margaret, widow of the late Rev. Richard Burton, of Alverstoke, and daughter of the late W. H. Allchin, surgeon, of East Malling, Kent, aged 76.

COCK.—On August 30th, at 147 Queen's Road, Peckham, Herbert Edgecombe, M.B.C.S., L.R.C.P., aged 33, eldest son of Dr. and Mrs. Cock.

COLLINGS.—On August 31st, at Spaxton Rectory, near Bridgwater, in her 84th year, Georgina, widow of the late Adolphus Collings, M.D., of Guernsey, and daughter of the late Honourable J. Nurse, of Ashbury, Barbados, West Indies.

CROSSMAN.—On September 1st, at White's Hill, Hambrook, Bristol, Edward Crossman, M.D. in his 72nd year.

WOODS.—On August 30th, at Inglewood, The Avenue, Bushey, Herts., Emily Rosamond Woods, daughter of the late Captain John Kulpe, formerly 5th Dragoon Guards, of Spring Hill, Borris in Ossory, Queen's County, Ireland, and widow of the late W. H. Woods, M.D., M.A., T.C.D., et Oxon, B.N., in her 82nd year.

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### INTRODUCTORY REMARKS.

THE choice of a future career is clearly one of the most momentous problems with which a young man can be faced. Its decision must be necessarily guided by many influences, some of them obvious enough, while others can be appreciated and explained only by wisdom acquired at the shrine of experience. The first great thing to be considered is whether the youth has any special aptitude or what is usually described as a "liking" for any one particular calling in life. Without such inclination it is to the last degree unwise for any person deliberately to embrace the study of the healing art. Of all the learned professions that of medicine demands the most affectionate and whole-hearted allegiance from her children. At the same time it is unhappily true that the ranks of medical practitioners contain many who have drifted into their occupation and who lack the enthusiasm that alone can lift them out of the rut of incompetency. Much the same, however, may be said of all intellectual pursuits.

As regards the material rewards of the profession of medicine the aspirant should recognise from the outset that the labourers are many and the harvest small. Any man who wishes to amass a fortune before he has attained middle age had better make up his mind to follow some business occupation. As a medical practitioner he will, in most instances be able to make enough to live upon within a short time of starting practice. Where there is much competition, however, he will find it hard to get much beyond that sum, and as a rule his increased income is swallowed up by greater proportionate expenses. A large general practice can be built up only by years of hard and conscientious work, at the end of which the practitioner will probably have amassed a moderate fortune. In all cases he will find it desirable to be provided with a sufficient sum of money either to buy a practice or to furnish a house and tide over the first years of waiting. Should he wish to enter the Public Health Service he will have to devote several years to acquiring a special knowledge of the duties to be performed in the office of a medical officer of health. Or he may prefer to enter the Army, Navy, or Indian Medical Services, which carry pay from the time of appointment and confer a pension upon retirement; latterly something has been done to render these Services more popular, but much remains to be done in that direction. Then there are lunacy, Poor-law, and Local Government Board appointments, some of them well-paid and highly responsible posts. Lastly, the medical student may have made up his mind to tread the honourable but thorny paths of the

consulting surgeon or physician, or of the specialist. In that case he must be provided with means to support him through ten years or more that will be required to enable him to make a livelihood. Many medical men whose names have become household words have had to endure many years of penury and self-denial. Indeed, no profession, not even excepting that of the barrister, could furnish more instances of hard living and high thinking than that met with in the ranks of consultant surgeons and physicians. On the other hand, the prizes to be gained in the higher branches of the profession are considerable, when tested by such acquisitions as social position, titles, honours, influence and substantial income. At the same time it must be borne in mind that not a few men of unblemished reputation and of great intellectual and professional acquirements live and die without having gained the favours of fortune. To succeed in these directions requires the possession of moderate means, average intellectual endowments, good education, a hospital appointment, a good address, and an iron resolution.

The rewards of medicine, then, are not to be measured by their bank value. Any medical man who conscientiously follows the practice of his profession, who is sympathetic to the suffering, who scorns delights and lives laborious days, and who makes "duty" and "responsibility" his watchwords, will most certainly rejoice in the esteem and consideration of his fellow citizens. The key to nine-tenths of the situation is admirably given in the aphorism which says that "Medicine is a wholly admirable profession, but for the most part not a good business."

There is in the study and practice of medicine ample scope for talents of the most varied kind. If, unfortunately, a tendency manifests itself in the daily practice of the healing art to fall into a routine, to treat disease by rule of thumb, that is the fault, or the defect, of the individual practitioner. The calling is one in which the individual practitioner is called upon to exercise independence of judgment, seeking in his own sphere to winnow the wheat from the chaff in the huge collection of principles, dogmas, and views bequeathed to us by our predecessors in the profession. We would impress upon every intending student that it lies with him to utilise the experience which will be his to assist in throwing light into dark corners—not so much by the publication of an occasional case of exceptional interest, but by endeavouring to deduce some general law, some vital principle, from the morbid phenomena which come under his notice. He should never forget that he is always a student—no longer a listener at compulsory lectures but perforce an observer, more-

or less thorough, more or less conscientious, of the working of Nature's laws, some of which we see as through a glass darkly, but of others we know little or nothing. Some epoch-marking discoveries have come from the ranks of the general practitioner, and assuredly it is never the material that is wanting.

#### THE CHOICE OF A SCHOOL.

The question of the choice of a medical school is often determined, so to speak, by accidents of time, place, and tradition. Many students nowadays go to one of the excellent provincial schools in their neighbourhood. Many others again, are attracted to the Universities, North or South of the Tweed, or across the Irish Channel, which grant the degree of M.D. without exacting an abnormally high standard of examination. Men who are receiving their general education at one of the universities will naturally enter the medical school attached to their Alma Mater, at any rate for a portion of the five years' medical curriculum. In some few instances the possession of a University qualification is made a *sine quâ non* in the holding of some coveted hospital or other professional appointment. There may be some sort of excuse for this species of organised "protection," which the labouring classes would call "trades-unionism," in the case of the professorships and examinerships in some of the ancient Universities. When a similar exclusion, however, is applied by medical charities the situation becomes intolerable. The fact remains, however, that in the majority of English hospitals and infirmaries none but London graduates and diplomates need apply. A newly formed association of Scotch Diplomates—many of whom are Englishmen and Irishmen—are calling attention to the unfairness of the conditions that exclude them from holding honorary appointments on the medical staffs of many English charities. These facts may possibly furnish useful hints to the intending student, who has to make the best of present conditions.

#### THE CHOICE OF QUALIFICATIONS.

No sooner has the study of medicine been entered upon than the student is called upon to define his aims; in other words, he has to decide through what portal he will enter the profession. The point is one of unquestionable importance, because there is no going back on the choice later in the student-career. The reorganisation of the University of London has rendered it possible for the average student to obtain a degree in medicine on terms less prohibitive than was formerly the case, but the fact remains that although the purely medical standard is attainable by any fairly diligent student, the matriculation examination and that in science nevertheless constitute serious stumbling blocks. The average student will probably find it more convenient to take the diplomas of the English Conjoint Board, and, should he deem a degree worth the extra trouble, he can put in attendance at one or other of the provincial Universities with the view of subsequently passing the examinations for the doctorate. Or he may choose to take a qualification or degree in the Scotch or the Irish schools, where education is sound, practical, and well-equipped, and the traditions of the teachers unrivalled. ■

#### THE COURSE OF STUDY.

It is unnecessary to discuss the details of the medical curriculum. We would, however, impress upon the student the importance of entering upon his work earnestly, with firm determination to familiarise himself with the subjects—*anatomy, physiology, and materia medica*—which constitute the threefold basis of practical medicine. And in respect of anatomy, the only valuable knowledge is that gained by actual

dissection of the dead body. Verbal descriptions and plates are only aids to knowledge, not knowledge itself. Dissection gives information at first hand—actual knowledge, not mere statements—and the practice of dissection is, in fact, a first course in surgery. We would warn the student against that form of intellectual laziness which consists in abandoning the dissecting-room in favour of the library. The latter course may enable the student to pass examinations, but it will never confer that intimate familiarity with the things themselves which is indispensable to success in practice. Nor should he despise that somewhat arid subject, *materia medica*. A knowledge of the physical properties of drugs and of their physiological action is all-important, to the hospital physician as to the general practitioner. Treatment is the ultimate object of all medicine, and the medicinal treatment of disease is still an integral part of the practice of medicine.

#### THE CLINICAL WORK.

It is in the wards and in the out-patient department, after all, that the student acquires most of his information concerning the course and treatment of disease. There he watches the daily progress of morbid processes, and learns the means employed to afford relief or to bring about recovery. It will be his privilege to unravel the tangled threads of each patient's life-history, and by the careful examination of data to arrive at a reasoned conclusion known as the diagnosis. In this way he will gradually learn to recognise the main principles which underlie the practice of medicine. Each patient who comes under his observation will, if properly studied, yield his quota of practical knowledge, and the value of the opportunity depends upon the ability and willingness of the student to avail himself thereof. The object and aim of clinical training is to cultivate the student's powers of direct observation and to train him to make correct deductions, and the habit of careful observation is one which should become second nature. The instruction received in the wards is incomplete unless supplemented by the lessons to be learned in the post-mortem room. There the student can follow the morbid process to its conclusion. The post-mortem room is the natural complement of the ward, and it is often only in this room that the clinical problem is unravelled and the student enabled to observe the organic lesions which determined the symptoms he has been studying. Incidentally the student should learn as much as he can of the method of carrying out these examinations, for it falls to the lot of most practitioners to have to make such examinations, and errors of observation or appreciation may be fraught with the gravest consequences to possibly innocent persons.

#### THE HIGHER QUALIFICATIONS.

There remains the question of the higher qualifications, *e.g.*, the Fellowships of the Royal Colleges, which are indispensable to those who contemplate a hospital career, either as physician or surgeon. The Fellowship of the London Royal College of Physicians is not obtained by examination, but by selection from among the members, but it is nevertheless demanded as a necessary qualification in the holding of many hospital appointments. Candidates for the membership are required to pass a searching examination and to satisfy certain other requirements before they can be admitted thereto, and subsequent elevation to the Fellowship is largely a matter of personal influence, though merit *per se* is not a bar to selection. The Fellowship of the Royal College of Surgeons, on the other hand, is a purely professional distinction, and is open to anyone who can pass the examinations. It is advisable to pass the

first examination for the Fellowship as soon as possible after passing the first membership, in order not to have to go over the ground later a second time. The Fellowships of the Scotch and Irish Colleges of Surgeons are conferred after examination, but are not recognised by the majority of large English medical charities.

#### CHOICE OF A CAREER.

For five long years at a minimum the student's ambitions do not soar beyond the boards of examiners. To obtain the right to practise is, for the time being, the object of his existence. When he has entered the portals of the profession he is confronted with the question of deciding in what particular path he shall direct his energies. Many neo-practitioners, not unwisely, spend a year or two in resident appointments at their own hospitals or at some provincial hospital or infirmary. Others acquire a knowledge of the practice, as distinguished from the theory, of medicine by serving as assistant or locum tenens. Others, again, either join their parents in practice or purchase partnerships. Then, too, there are the Services—Indian, Army, Navy, and Colonial—to choose from. The Poor-law Infirmarys provide each year a certain number of appointments, and these are the first rungs of the ladder which leads to the superintendency of these institutions. These posts are fairly remunerated, and afford reasonable security of tenure, but they entail much hard work, together with heavy responsibilities.

#### PUBLIC HEALTH SERVICE.

Every student who can afford the time is strongly advised to qualify in State Medicine, since this diploma renders its holder eligible for appointment as medical officer of health, and, moreover, the knowledge thus gained is invaluable in every department of practice. A diploma in State Medicine entails a special course of preparation and training subsequent to qualification, the conditions of which will be found under the appropriate heading. Although the tenure of office is not as yet on a satisfactory basis, there are many appointments of the kind which afford a free field for intelligent activity.

#### POST-GRADUATE INSTRUCTION.

Medicine has, of late years, become a field of vastly wider extent and when he enters upon his professional work the conscientious practitioner is apt to experience a painful sense of his shortcomings in many branches of medical practice. The knowledge which has been rendered available of recent years has obviously placed a peculiar responsibility upon the physician fresh from his studies. The desire so generally felt by men in practice to extend and complete their knowledge of special subjects has led to the organisation of post-graduate institutions on a large scale, of which advantage is freely taken by those who are fortunate enough to reside within accessible distance thereof. We would strongly urge senior students and young practitioners to avail themselves of every opportunity to acquire a working knowledge of the various special branches—eye, ear, throat, gynaecology, and so on. This leads us to the question of

#### SPECIALISM IN MEDICINE.

Hitherto the student has been taught that "the greatest mistake of all is to start in a speciality without being thoroughly grounded in general practice." Admitting that it behoves everyone, no matter what particular department of practice he may decide to adopt, to have acquired a thorough grounding in the general principles of medicine, it is impracticable for him to devote much time to a general practice. On the contrary, there is much to be said in favour of the view that it is best for the young practitioner to make his

choice at the earliest possible moment of the line of work which he designs to follow. As soon as he has qualified, therefore, or as soon after as may be, the intending specialist should endeavour to obtain a junior post in one or other of the special hospitals, where he can gradually work his way up.

#### MEDICAL PRACTICE IN FOREIGN COUNTRIES.

Practitioners qualified in Great Britain who desire to practise their profession abroad are still confronted with many difficulties. True, a step in the direction of reciprocity has been taken in the case of Italy, but elsewhere in Europe considerable difficulty will be experienced in obtaining permission to practise; indeed, with the one exception of Italy, it is usually necessary to go through the whole curriculum and pass the examinations in their entirety.

#### LONDON SCHOOLS.

**The Schools of Medicine in the Metropolis are the following, the scholarships, prizes, students' appointments, fees, &c., being set forth in connection with each place named. The names of the hospital staff, lectures, residential terms, and detailed information will be found, as a rule, in our advertisement columns.**

**ST. BARTHOLOMEW'S HOSPITAL.**—This hospital has 750 beds, and for many years past the school attached has had a larger number of entries than any other medical school in London. New laboratories have been specially equipped for the study of pathology, bacteriology, chemistry, and chemical pathology. Collegiate residence is here permissible, subject to the ordinary rules. The recreation ground for the use of students is at Winchmore Hill.

**Appointments.**—Ten house physicians and ten house surgeons are appointed annually. During the first six months of office they act as "junior" house physicians and house surgeons, and receive a salary of £25 a year. During their second six months they become "senior" house physicians and house surgeons, and are provided with rooms by the hospital authorities, and receive a salary of £80 a year. A resident midwifery assistant and an ophthalmic house surgeon are appointed every six months, and are provided with rooms and receive a salary of £80 a year. Two assistant anaesthetists are appointed annually, and receive salaries of £120 and £100 a year respectively. An extern midwifery assistant is appointed every three months, and receives a salary of £80 a year. Chief assistants and clinical assistants are appointed in each of the special departments. In-patient dressers, in-patient clinical clerks, clerks, and dressers to the assistant physicians, and to the physicians and surgeons in charge of special departments are appointed every three months without fee.

**Scholarships, &c.**—There are four open scholarships in science, £75, £75, £150, £50, tenable for one year, and a Jeaffreson exhibition, value £20; at the end of first year four junior scholarships of £30, £20, £25, £15, respectively; Treasurers' prize for practical anatomy; Foster prize in practical anatomy; senior scholarships, value £50, for anatomy, physiology, and chemistry; Wix prize, Hichens prize, Lawrence scholarship and gold medal, value 40 guineas, for medicine, surgery, and midwifery; two Brackenbury scholarships, of £39, in medicine and surgery; Bentley prize, for reports of surgical cases; the Kirkes gold medal for clinical medicine, with scholarship of £30. Shuter scholarship of £50; Skyunner prize of £15; Sir G. Burrows' prize of £10, and Matthews Duncan medal and prize, value about £20.

**Fees.**—By payment of an annual composition fee, a student is entitled to attend all the courses of instruction, and to hold the various clinical appointments. For students commencing their medical studies:—Entrance fee, 30 guineas; annual fee, 30 guineas, for five years. A student on qualification at the end of the five years is not liable for any further fees, and receives a perpetual ticket. Should he fail to qualify in this time,

the fee for further instruction is 10 guineas for each six months. Fees for University students:—Entrance fee, 20 guineas; 30 guineas annually for two years, and 10 guineas for each six months if not qualified. Fees for preliminary scientific students:—20 guineas; for laboratory instruction for D.P.H., 15 guineas.

The Warden, Mr. W. D. Harmer, will furnish further details on application.

**CHARING CROSS HOSPITAL.**—The school attached to this hospital is situated in central London, and contains new physiological, pathological, and bacteriological laboratories, materia medica and anatomical museums, an anatomical theatre, enlarged dissecting-room, and chemical theatre. The hospital and convalescent home contain 300 beds available for clinical study.

Clinical instruction is given in medicine, surgery, and obstetrics, and in the special department, diseases of the skin, diseases of children, mental disorders, the throat, the eye, nose and ear, and in the orthopædic, Röntgen, and electrical departments.

**Scholarships, Medals, &c.**—The Livingstone scholarship (100 guineas), the Huxley scholarship (55 guineas), and six other entrance scholarships, total value £550, are awarded annually. Two scholarships of the value of 72 guineas each are reserved for students of Oxford, Cambridge, or London Universities. All are awarded annually. Two Universities scholarships, value 72 guineas each, are open to students from the University of Oxford who have passed the 1st M.B., to students of the University of Cambridge who have passed the 2nd M.B., and to students of the University of London who have passed the intermediate examination in medicine. Candidates must give notice to the librarian of their intention to compete on or before September 24th, 1904. The Golding prize of £10 is open to students at the end of their first winter session. The Huxley medal, with prize of £10, is open to students at the end of their second winter session. The Pereira prize of £5 is open to all general students. The Llewellyn prize of £25 is awarded annually at the end of the curriculum. The Governors' Clinical Gold Medal is also open to students at the end of their curriculum, and a silver medal or its equivalent in books is awarded to the most distinguished student in each class.

**Appointments.**—The curator and pathologist is appointed annually, and receives £100 a year; medical and surgical registrars to the hospital receive £40 a year each, with luncheon in the hospital; obstetric registrar, six house physicians, six house surgeons, and two resident obstetrical officers are appointed each year; clinical clerks and dressers are appointed in all the general and special departments of the hospital.

**Fees.**—For the curriculum of study required by the various examining bodies and hospital practice, 115 guineas in one sum, or 126 guineas in five instalments.

The composition fee for sons of registered medical practitioners is 105 guineas, and the fee, by instalments, 115 guineas. For dental students, 55 guineas in one sum, or 61 guineas payable in two instalments of 31 and 30 guineas respectively.

**St. GEORGE'S HOSPITAL.**—This hospital is centrally situated in the West End, facing Hyde Park. It contains 356 beds, and special wards for ophthalmic cases and diseases of women.

**Appointments.**—Four house physicians and four house surgeons, entitled to reside and board in the hospital free of expense; four general assistants, four assistants in the special departments. Candidates for the above offices are selected quarterly by competition from among the perpetual pupils, sixteen pupils being in office at any one time. Obstetric assistant with a yearly salary at the rate of £50 and board and residence in the hospital; curator of the museum with a salary of £200; assistant curator with a salary of £100; two medical registrars, with salaries of £200 per annum; a surgical registrar with a salary of £200 per annum; an administrator of anæsthetics with a salary of £50 and two with salaries of £30 per annum; a surgery officer with a salary of £100 a year; two or more demonstrators of anatomy with a salary of £50 each;

and assistant demonstrators. All offices are open to candidates without additional fee.

**Exhibitions, &c.**—The Brown exhibitions, one of £100 per annum, tenable for two years, and open to perpetual pupils possessing a registrable diploma; and one of £40 per annum, tenable for three years and open to students of two years' standing or upwards, who at the time of competition have not been qualified to practise medicine and surgery for more than three years. The Brackenbury prizes of the value of £40 each, one each in medicine and surgery. The Webb prize in bacteriology, value £30. The Clarke good conduct and clinical work prize in surgery, the Thompson medal, the Brodie clinical prize in surgery, the Johnson prize in anatomy, the Pollock clinical prize in physiology, the Treasurer's prize for clinical reports, and four general proficiency prizes of ten guineas each.

**Scholarships.**—One in Arts, of £100. One in Science, of £100. Examination, September 20th. One of £50 in anatomy and physiology, open to students who have passed a recognised examination in anatomy and physiology.

**Fees.**—Composition fee for perpetual pupils, £150 or £160, in the following instalments: First year £50, second year £50, third year £40, fourth year £20. The fee for general subjects in dental surgery is £55, payable in two instalments: first year £30, second year £25. Only perpetual pupils can hold house office or compete for the Brown exhibitions.

**GUY'S HOSPITAL.**—This hospital is situated on the Surrey side of London Bridge, and contains 602 beds in constant occupation. There are special wards for ophthalmic and obstetric cases, eight beds in the latter being appropriated for difficult cases of labour. Some beds have also been set apart for diseases of the ear and throat, and an "isolation" ward for cases of infectious diseases arising in the hospital has been constructed. An obstetric registrar and tutor and an ophthalmic registrar and tutor are appointed to augment the teaching in the special departments, in addition to those attached to the general surgical and medical wards. Attached to the hospital is a large residential college with rooms for about sixty men, whilst for students who prefer to live in the suburbs, no other hospital is so conveniently placed, the railway accommodation being good and close at hand. There is a complete School of Dental Surgery at this Institution, which is recognised by the Royal College of Surgeons of England; the facilities thus afforded of completing the whole course of dental study within the walls of one hospital will be appreciated by those intending to practise dentistry.

**Appointments.**—Eight house surgeons, eight house physicians, eight assistant house physicians, twenty-four assistant house surgeons, eight obstetric residents, two ophthalmic house surgeons, twenty-four clinical assistants, and ninety-six dressers are selected annually from the students according to merit, and without payment. There are also a large number of junior appointments, every part of the hospital practice being systematically employed for instruction.

**Scholarships.**—Open scholarships of £100 and £50 in classics, mathematics, and modern languages. Open scholarships of £150 and £60 in chemistry, physics, and biology, and an open scholarship of £50 for University students in two of the following subjects:—Anatomy, physiology, organic chemistry, zoology, physics. The following are the scholarships, prizes, and medals open to students of the hospital:—The Arthur Durham prizes for dissection, £15 and £5; Junior prizes for general proficiency, £20, £15, £10; Hilton prize for dissection, £5; Michael Harris prize for anatomy, £10; Sands Cox scholarship for physiology, £15; Wooldridge prize for physiology, £10; Beaney prize in pathology, £34; Golding-Bird prize in bacteriology, gold medal and £20; Treasurer's gold medal in clinical medicine; Treasurer's gold medal in clinical surgery; Beaney studentship in materia medica (tenable for 3 years), annually £31 10s.; Gull studentship in pathology (tenable for 3 or 5 years), annually £150.

**New School Buildings.**—A considerable addition to the school buildings was made in 1897, comprising a



series of class-rooms, laboratories, and a lecture theatre for the teaching of physiology. In 1903 the magnificent Wills Library was opened, and a new museum for pathological specimens and additional lecture and class rooms are in course of erection.

**Fees.**—A new system for payment of composition fees has been recently instituted at this school. Particulars may be obtained on application to the Dean, Guy's Hospital, London Bridge, S.E.

**KING'S COLLEGE HOSPITAL.**—This hospital is centrally situated, being contiguous to the Royal College of Surgeons, Lincoln's Inn Fields. The College adjoins Somerset House and is close to the hospital, in which there are 220 beds available for clinical teaching; ophthalmic, ear, throat, skin, and dental departments are attached to the hospital. Some wards are specially devoted to children's diseases. The wards have been recently refloored and the electric light installed throughout.

**Scholarships.**—£800 are awarded annually in scholarships and prizes. At entrance, a science exhibition of £100 value is open to all candidates under the age of nineteen; two scholarships of the value of £100 each (subjects literary) are open to students commencing their curriculum. A scholarship, value £50, is open to students of a British University who come up to London to complete their curriculum; two junior scholarships of £20 each for first year students, one of £30 for second year students, one of £50 for third year students in residence, and one of £40 for fourth year students. In addition, students may compete for the Daniell scholarship, value £40; the Warnford prizes, value £40; the Rabbeth scholarship, value £20; the Carter, Todd, Jelf, Tanner, Leathes prizes, and all class and clinical prizes.

**Appointments.**—Medical and surgical Sambrooke regisrations, tenable for two years, each £50 per annum. Resident hospital appointments, *viz.*, senior and junior house physicians, assistant house physician, physician accoucheur's assistant and assistant house accoucheur, and three house surgeons with free board and residence at the hospital; and senior and junior clinical assistants in special departments.

**University of London.**—Special courses of lectures and practical instruction in the chemical, physical, physiological, and other laboratories have been arranged for students preparing for preliminary scientific intermediate science and other examinations of the University of London.

**F.R.C.S. Examinations.**—Special classes are arranged for the final F.R.C.S. examinations. Further particulars can be obtained from the Dean.

**LONDON HOSPITAL.**—This hospital is the largest in England, containing, as it does, 820 beds. It has, moreover, wards and a teaching staff for almost every special department in the domain of medicine; the scholarships and prizes are many and valuable, and both school and staff are deservedly popular with students.

**Appointments.**—The "House" appointments, which are numerous, are made without fee of any kind, and all resident officers are provided with free board and rooms, and in some instances with salary also.

The additional buildings for the department of public health, for the biological, chemical, and physical laboratories, *matéria medica* museum, &c., and the new bacteriological department with general laboratory, research laboratories, class rooms for D.P.H. work, sterilising room, animal room, &c., are now open.

**Fees.**—Perpetual fee for lectures, demonstrations, and hospital practice, payable in three instalments of 45, 45, and 40 guineas at the commencement of the first, second, and third years respectively, 130 guineas; or, if in one payment, 120 guineas. Fee for students entering in their third year (their first and second years having been spent at a recognised medical school elsewhere), 60 guineas. This fee is payable by students entering who have passed the first M.B. Oxford; the second M.B. Cambridge; or the Intermediate M.B. London. Dental students (general hospital practice and lectures), 40 guineas. General fee for dental practice, 10 guineas.

**Note.**—A reduction of 15 guineas will be allowed to the sons of medical men from the perpetual fee if paid in full, or 5 guineas from each instalment.

Special entries can be made either for single courses of lectures or for hospital practice.

Accommodation is obtainable at a very reasonable rate close by, or in the suburbs a few minutes' distant by train. Fuller particulars can be obtained of the Warden, Mr. Munro Scott.

**ST. MARY'S HOSPITAL.**—This hospital is situated at Paddington, near the terminus of the Great Western Railway, and at present contains 281 beds. Fresh laboratories, fitted with electric light and all modern improvements, for the study of pathology and bacteriology, have recently been added, and also a new physiological lecture-room. A special department of pathological chemistry has been instituted. The new wing, the ground-floor of which, comprising the new out-patient department, was opened in 1898, is now approaching completion; this will raise the number of beds to 350, and will include additional operating theatres, a new clinical laboratory, a clinical theatre, and an X-ray department.

**Appointments.**—All clinical appointments in the hospital are free to students of the Medical School, and the resident medical officers are chosen by competitive examination. Six house physicians, six house surgeons, four obstetric officers, and two resident anaesthetists are appointed in each year, and receive board and residence in the Hospital.

**Scholarships, &c.**—One scholarship in natural science, of the value of £145, open to any gentleman who has not completed a winter session of study at a medical school. One scholarship in natural science, of the value of £78 15s., and two of £52 10s., under the same conditions. Two scholarships, each of 60 guineas, open to students from any British University. The scholarships will be awarded by examination on September 20th and 21st.

**Fees.**—Fee for attendance on the full five years' curriculum of hospital practice and all lectures, demonstrations, and special tutorial classes, £140, paid in one sum on entering the school; or in instalments, £145.

Students who have completed their examinations in anatomy and physiology at the Universities of Oxford, Cambridge, or other University, are admitted as perpetual pupils on payment of a fee of 60 guineas in one sum, or 65 guineas in two annual instalments. University students, prior to completing the anatomy and physiology examinations, pay an annual fee of 25 guineas. After completing the anatomy and physiology examinations, the inclusive fee may be paid.

**Preliminary Scientific Course.**—Special classes, under recognised teachers of the university are held throughout the year.

**MIDDLESEX HOSPITAL.**—This hospital, which is conveniently situated in the centre both of business and residential London, contains 340 beds. There are special departments for cancer, and for ophthalmic, throat, aural, skin, dental, children's diseases, and electrical treatment (X-ray and Finsen light). Wards are also devoted to cases of uterine disease. The new school buildings are now in regular use. Residence for students is obtainable in the residential college, which has its frontage on the hospital garden.

**Appointments.**—Casualty surgical officer, casualty medical officer, six house surgeons, six house physicians, and two resident obstetric physicians. The above officers have residence and board in the college free of expense. Clinical clerks and dressers in all the departments are also appointed in addition to the foregoing.

**Scholarships, &c.**—Two entrance scholarships of the value of £100 and £60 respectively. One entrance scholarship of the value of £60, open to Oxford and Cambridge students only. (Subjects—Anatomy and physiology, including histology). "Emden" Cancer Research Scholarship, £100. "Richard Hollins," Research Scholarship, £105. Two Broderip scholarships of £60 and £40 respectively, for medicine and surgery; John Murray medal and scholarship, awarded every third year; the Governor's prize of £21

for students in their final year. Hetley clinical prize, value £25, awarded annually for proficiency in practical clinical medicine, surgery, and obstetrics; the Lyell Gold Medal in surgery and surgical anatomy; the Leopold Hudson prize, value 11 guineas, in surgical pathology, including bacteriology; Freeman scholarship, £30, in obstetrics and gynaecology; exhibitions of 10 guineas and 5 guineas for anatomy and physiology to second and first year's students respectively, as well as class prizes in all subjects.

**Fees.**—General fee for the entire course of hospital practice and lectures, 135 guineas, if paid in one sum on entrance, or by instalments of 60, 50, and 35 guineas, payable at the commencement of the first, second, and third year respectively. For those who have completed their anatomical and physiological studies the fee is 70 guineas on entrance, or in two instalments of 40 and 35 guineas. The composition fee for London University students is 145 guineas. For those who have passed the preliminary science examination 120 guineas. The fee for the curriculum for dental students is 54 guineas on entrance, or two instalments of 40 guineas and 20 guineas.

**ST. THOMAS'S HOSPITAL.**—This hospital, with medical school attached, is situated on the southern Embankment of the Thames, facing the Houses of Parliament, and contains 602 beds, of which about 540 are in constant use. The school buildings, which are separated from the hospital by a quadrangle, comprise numerous theatres, laboratories, and class rooms, which are well adapted for the modern teaching of large bodies of students in all subjects of the medical curriculum. There is a large library and reading-room, and a very complete museum and gymnasium.

**Appointments** are open to all students. A resident assistant physician and a resident assistant surgeon are appointed annually at a salary of £100 with board and lodging; two resident casualty officers at a salary of £100 per annum. Two hospital registrars, at an annual salary of £100 each, are appointed yearly. The tenure of these offices may be renewed for a term not exceeding two years. An obstetric tutor and registrar is appointed each year at an annual salary of £50. Four house physicians, two house physicians to out-patients, four house surgeons, four house surgeons to out-patients, two obstetric house physicians, two ophthalmic house surgeons, and eight clinical assistants in the special departments are appointed every three months.

**Scholarships, Prizes, &c.**—Three entrance scholarships are offered for competition in September, *viz.*, one of £150 and one of £60 in chemistry, physics, and biology at the commencement of the second year; one of £50 open to University students who have passed in anatomy and physiology, for a medical degree in any of the Universities of the United Kingdom, and have not entered as students in any London Medical school. Numerous scholarships, prizes, and medals are open to competition throughout the whole career of a student, including a Fellowship of £100 given by the Salters' Company for research in pharmacology.

Special courses of instruction for the Preliminary Scientific and Intermed., M.B.Lond., for the Oxford and Cambridge examinations, and for the Primary and Final F.R.C.S. are held throughout the year.

A register of approved lodgings is kept by the medical secretary, who has a list of local medical practitioners and others who receive students into their houses. The prospectus of the school may be obtained on application to Mr. Rendle, the medical secretary.

**UNIVERSITY COLLEGE, LONDON, AND HOSPITAL.**—This hospital is situated in Gower Street, not far from Euston Railway terminus. The college in which the classes are held faces the hospital, on the opposite side of the street. The number of beds available for teaching purposes is 191.

**Appointments.**—Eight house physicians, six house surgeons, four senior and four junior obstetric assistants, and two ophthalmic assistants are selected annually by examination from among the senior students, without fee. The house physicians and house surgeons reside in the hospital for a period of six months, and the senior

obstetric assistants for three months, and receive their board and lodging free.

The offices of out-patient physicians' and surgeons' assistants, clinical clerks, surgeons' dressers, and ophthalmic surgeons' assistants are filled by pupils who are also students of the college, without additional fee.

**Scholarships, &c.**—Entrance scholarships (examination begins on September 20th, at 10 o'clock): One of the value of £120, and two of 60 guineas for proficiency in science, the subjects being those of the Preliminary Scientific Examination of the University of London, and two of 80 guineas each, the subjects being anatomy and physiology; the Atkinson-Morley surgical scholarship of £45 a year, tenable for three years; Atchison's scholarship, value £55, tenable for two years; Sharpey physiological scholarship, value about £105 a year; Filliter exhibition for proficiency in pathological anatomy, value £30; Erichsen prize, operating case, value £10 10s., awarded for practical surgery, Dr. Fellow's clinical medals, the Liston gold medal, Alexander Bruce gold medal, Cluff memorial prize, Tuke medals for pathology, class medals, &c., gold and silver medals or other prizes, as well as certificates of honour, are awarded after competitive examinations in particular branches of study. The Tuffnell scholarship of £80 for chemistry, two years; and the Clothworkers' exhibitions in chemistry and physics of £30 each, can also be held in the medical faculty.

**Composition Fees.**—The following have been grouped to meet the requirements of the various examining boards:

**A.**—For the Courses required by the University of London. 1. For the Preliminary Scientific course: 25 guineas, entitling to one attendance. 2. For the Intermediate Course: 60 guineas, if paid in one sum; 62 guineas if paid in two instalments. 3. For the Final M.B., B.S. Course: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments. This course of instruction is also suitable for the corresponding Examinations at the Universities of Oxford, Cambridge, and Durham.

**B.**—For the Medical education required by the Examining Board in England and the Society of Apothecaries: 4. For the Course required for the First Examination: \*30 guineas entitling to one attendance. 5. For the Second: 50 guineas, if paid in one sum; 51 guineas, if paid in two instalments. 6. For the Course required for the Third Examination: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments.

The composition fee in each case entitles to attendance on Lectures and Hospital Practice during three years.

**C.**—For Dental Students. Composition fee for the Courses required for the L.D.S., 65 guineas; or exclusive of Chemistry, Practical Chemistry, Physics, and Materia Medica, 50 guineas.

\* Students may repeat attendance at the Courses in Chemistry and Physics for £3 3s. (inclusive) and in Elementary Biology for £2 2s.

**WESTMINSTER HOSPITAL.**—This hospital is conveniently situated, facing the Abbey, and is readily accessible from all parts of the Metropolis. It contains 205 beds for general cases, and all the special departments. New school buildings have been erected close by which afford accommodation for 150 students. The class rooms, dissecting rooms, and lecture theatre are excellent samples of modern erections, affording ample scope for study.

**Appointments.**—Medical and surgical registrars, each £40 per annum; two house physicians, two house surgeons, two assistant house surgeons, and resident obstetric assistant. These officers, except the two first named, are all boarded free of expense. Fourth year's students are appointed to be clinical assistants in the various departments.

**Scholarships, &c.**—(a) Winter Session—The Guthrie scholarship £60, entrance scholarship £40, entrance scholarship £30, dental scholarship £20; subjects, Latin, mathematics, experimental physics, chemistry, and either Greek, French, or German. University

scholarships, £40 and £30; subjects, anatomy and physiology. Natural science scholarship, £60, same as for Prel. Sci. of University of London. Natural science scholarship, £40, chemistry and physics. Free presentation, open to pupils of Epsom Medical College. (b) Summer Session.—Natural science scholarship, £60, same as winter. Natural science scholarship, £40, same as above. Arts scholarship, £60, arts scholarship, £40, University scholarships, £40 and £30, subjects same as in winter session. (c) Prizes.—Treasurers', 10 guineas, for first year's men; Chadwick, 20 guineas for students of any year not exceeding fifth. To be competed for by unqualified men. Bird medal and prize, £14, for students who have completed fourth winter session. Sturges prize in clinical medicine, £8, clinical surgery prize, £5, to be competed for by unqualified men. And class prizes in the various subjects.

**Fees.**—In one payment of 110 guineas, or two payments of 60 guineas each, payable on entrance and at the commencement of second year respectively, or by six payments distributed over six sessions of 25 guineas and 20 guineas alternately. Fees for shorter periods or for single courses may be learned on application to the Dean. Fees for dental students, payable in one sum on entrance, 50 guineas, or in two instalments of £27 10s.

**LONDON SCHOOL OF MEDICINE FOR WOMEN (ROYAL FREE HOSPITAL).**—This school, which is situated in Hunter Street, Brunswick Square, opens at the same time as, and the periods of study, lectures, &c., are similar to those at, the ordinary medical schools. A dissecting-room, physiological, chemical, biological, physical, and pharmaceutical laboratories and library are provided at the school, and clinical lectures are regularly delivered at the Royal Free Hospital close by, which institution is appropriated to the students at the School as a field of practical study; all clerkships and dresserships are open to the students of the School. Resident and other posts are open to the students after qualification. Numerous scholarships and prizes are awarded, particulars of which can be obtained on application.

**Fees.**—The fee for the Intermediate and Final M.B. Lond. Course is £95 if paid in one sum, or £100 if paid in three instalments. The fee for the Course for the Conjoint Colleges of Scotland, &c., including Elementary Science, is £105 if paid in one sum, or £110 if paid in three instalments. The fee for hospital practice and clinical teaching is £40, or £45 if paid in instalments.

Special classes for the Preliminary Scientific examination of the University of London, For the whole course, £25.

### EXTRA-ACADEMICAL INSTITUTIONS IN LONDON.

**NATIONAL DENTAL HOSPITAL.**—This institution is centrally situated (Great Portland Street, W.), and excellent teaching facilities and hospital practice are here obtainable, special demonstrations being given by members of the staff. There are also a mechanical laboratory, bacteriological laboratory, museum, students' common room, a metallurgical laboratory, extraction and stopping rooms, lecture hall, regulations room, &c., all lighted by electricity, and warmed and ventilated after the most approved requirements; in fact, this institution may be pronounced a model dental hospital and school. The winter session commences at the same time as at the medical schools, on October 3rd. The medical tutors hold special classes before each college examination. The prizes include two entrance exhibitions, value £40 and £20, and the Rymer prize of £5 ss., the examinations for which are held in May and October. The fee for two years' hospital practice required by the curriculum, including lectures, is £40. (See advt.)

**LONDON SCHOOL OF DENTAL SURGERY.**—The teaching and hospital practice at this institution, like that at the foregoing, are recognised by the Royal College of Surgeons for the dental diploma. It is situated in Leicester Square, is open daily, and under the supervision of a special staff and house surgeons. The Hospital having been rebuilt recently,

the accommodation is equal to all requirements. There is the Saunders scholarship and Entrance scholarship, value £20 each, the Woodhouse Prize of £10, and other prizes awarded yearly, the Storer Bennett Research scholarship, value £50, awarded triennially, and the five house surgeoncies are filled by students of the hospital holding the L.D.S. Fee for two years' hospital practice required by the curriculum, including lectures, £56 6s. The fee for three years' tuition in mechanical dentistry and the two years' hospital practice as required by the curriculum is £175 if paid in one instalment, or 75 guineas, 50 guineas, and 50 guineas if paid in three instalments. For tuition in mechanical dentistry the fee is 50 guineas per annum.

**LONDON SCHOOL OF TROPICAL MEDICINE.**—This Institution is the outcome of a suggestion by the Right Hon. Joseph Chamberlain, H.M. late Secretary of State for the Colonies, and is situated at the Royal Victoria Docks, in connection with the Seamen's Hospital, than which no more suitable spot could be found, as ships arrive there in great numbers from the Tropics, affording immediate opportunity for the study of tropical diseases. The school buildings are placed within the hospital grounds, and systematic courses of instruction are obtainable from duly authorised teachers throughout the year. Students also have the privilege of attending the medical and surgical practice at the "Dreadnought" Hospital, Greenwich. Information as to fees, &c., can be obtained of the Dean or the Secretary.

**Medical students are admitted to the practice of the following Metropolitan hospitals, to which no medical school is attached. Detailed particulars will be supplied on application to the various secretaries.**

**WEST LONDON HOSPITAL, Hammersmith.**—This contains 154 beds, and has an extensive out-patient department. Dresserships and clinical clerkships may be obtained. Two house surgeons and two house physicians are selected every six months. Special departments have recently been opened for diseases of the throat, ear, skin, and deformities. Electrical and X-ray departments have also been added. The practice of this hospital is reserved exclusively for medical men, junior students not being admitted.

**GREAT NORTHERN CENTRAL HOSPITAL, Holloway Road, N.**—This institution has been recently enlarged, contains 159 beds, and is now recognised for study during the fifth year by the Conjoint Board. The practice of the hospital is open to practitioners and senior students, and clinical and pathological assistants are appointed in the wards and out-patient departments, as in the larger general hospitals.

**BETHLEM ROYAL HOSPITAL.**—Two resident house physicians who have recently obtained their diplomas to practise medicine and surgery are elected every six months, and are provided with apartments, complete board, attendance, washing, and an honorarium of 25 guineas per quarter. The students of certain specified London medical schools receive clinical instruction in the wards of the hospital, and qualified practitioners may attend for a period of three months on payment of a fee. Post-graduate lectures are also given.

**NATIONAL HOSPITAL FOR EPILEPSY AND OTHER DISEASES OF THE NERVOUS SYSTEM, Queen's Square, W.C.,** contains 200 beds. It has on its staff men of European reputation, and the institution is recognised by the Conjoint Board where part of the fifth year of study may be devoted to clinical work. Clinical clerks are appointed to the physicians for out-patients, and courses of lectures and clinical demonstrations are given each year.

**HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, Brompton.**—The largest institution for the treatment of affections of the chest in the United Kingdom, there being 318 beds in the two buildings. There are four house physicians, who reside in the

hospital, each for a period of six months. Lectures and demonstrations are given by members of the medical staff on Wednesdays and Fridays at four o'clock, save during the vacations. Terms, £2 2s. for three months; £5 5s. perpetual. This hospital is recognised by the Conjoint Board, the University of London, and the Apothecaries' Society.

**CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST,** Victoria Park.—This is a large and well-equipped hospital at the East End, containing 164 beds. Clinical lectures and demonstrations are given by the members of an exceptionally experienced staff. Fee for three months' attendance on hospital practice, 2 guineas; six months, 3 guineas.

**ROYAL HOSPITAL FOR DISEASES OF THE CHEST,** City Road.—(80 beds).—This hospital has been enlarged by the addition of a very complete out-patients' department, and also by the erection of a new wing, which provides accommodation for 80 in-patients.

#### THROAT AND EAR HOSPITALS.

**METROPOLITAN EAR, NOSE, AND THROAT HOSPITAL.**—The hospital was founded in 1838, and is situated in Grafton Street, Tottenham Court Road. The out-patient department is open daily at 2.30 p.m. to practitioners and students for acquiring clinical instruction and technical knowledge. Operations are performed on in-patients on Tuesdays, Wednesdays, and Thursdays at 9 a.m. Fee for one month's attendance at the hospital one guinea, and for three months two guineas. During the forthcoming session demonstrations will be given by members of the staff on the pathology and treatment of diseases of the ear and respiratory passages. Short practical classes will also be held in clinical pathology and surgical anatomy. Weekly clinical lectures are given by the staff on the special disease treated at the hospital, the date, time, and subject of these lectures are previously announced in the medical journals. Further particulars may be obtained upon application to the Hon. Secretary to the Medical Board, at the hospital.

**CENTRAL LONDON THROAT AND EAR HOSPITAL,** Gray's Inn Road, contains seventeen beds, with an extensive out-patient department recently enlarged. Clinical demonstrations and instruction to qualified practitioners and senior students daily during the hours of the surgeons' visits. Twelve clinical assistants, who must be duly qualified, are elected to assist the surgeons. Operation days—Tuesdays and Fridays, 2 p.m. Fees for the three months' attendance, £3 3s.; six months', £5 5s. Full details of this institution and post-graduate work will be found on reference to our advertising columns or on application to the Dean.

**HOSPITAL FOR DISEASES OF THE THROAT,** Golden Square, W.—This hospital has been recently rebuilt and contains 50 beds. Clinical instruction is given daily in the Out-patient Department on diseases of the nose, throat, and ear. There are nine clinics weekly, and an annual out-patient attendance of nearly 50,000. Major and minor operations daily (Mondays excepted) in different theatres. Four senior and forty-two junior clinical assistants are appointed from among the students to assist the surgeons. Students are admitted to the practice of the hospital at the following fees:—Three months, £5 5s.; six months, £7 7s.; perpetual attendance, £10 10s. Further details can be had by applying to the Dean.

#### WOMEN AND CHILDREN.

**THE HOSPITAL FOR WOMEN,** Soho Square.—The hospital contains 61 beds. In connection with this institution there is now an organised school of gynaecology open to qualified medical men and to students after their third year. Clinical assistants to the physicians and surgeons in the in-patient and out-patient departments are appointed every three months. Fee for the three months' course, and certificate, £8 8s.

**THE SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN,** Lower Seymour Street, W., offers excellent opportunities for clinical study and training in the details of operative gynaecology. The success of the staff in this department have gained for them a European reputation. There are 47 beds.

**HOSPITAL FOR SICK CHILDREN** in Great Ormond Street, Bloomsbury, W.C., and Cromwell House, Highgate.—Fee for three months' attendance, £2 2s.; perpetual, £3 3s. There are now 200 beds, besides 52 additional at the convalescent branch, and it is probably the largest institution of the kind in the world. The practice of the hospital is open to pupils of the different hospitals and medical schools of London and medical practitioners on conditions to be ascertained from the Secretary.

#### EYE HOSPITALS.

**ROYAL LONDON OPHTHALMIC HOSPITAL,** formerly in Moorfields, and recently rebuilt in the City Road, is the largest hospital devoted to this specialty in Great Britain, and contains 138 beds. Students and practitioners are admitted to the practice daily at 9 o'clock. Operations, 10 o'clock and after. Fee for six months, £3 3s.; perpetual, £5 5s. Further particulars of the Secretary.

**ROYAL WESTMINSTER OPHTHALMIC HOSPITAL,** adjoins Charing Cross Hospital in King William Street. It has about 34 beds and a very large out-patient *clinique*. The lectures and demonstrations are arranged with special reference to the requirements of practitioners and senior students. Fee, six months, £3 3s.; perpetual, £5 5s.

**ROYAL EYE HOSPITAL,** St. George's Circus, Southwark.—There are 40 beds and two cots. Fees, £2 2s. for three months, £3 3s. for six months, and £5 5s. perpetual. Courses are held on ophthalmoscopy, refraction, and diseases of the eye; fee, £1 1s. for each course, but perpetual students may attend each course once without extra fee. Pathology class, £1 1s. extra to cover cost of materials.

#### SKIN HOSPITALS.

**ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN.**—Out-patient department, Leicester Square; In-patient department, Uxbridge Road, W. This hospital has a well-equipped in-patient department, with 50 beds. It has a School of Dermatology at 49 Leicester Square, which is conducted by the medical staff of the hospital. A spacious laboratory is also provided. During the past year the free course of Chesterfield Lectures given by Dr. Morgan Dockrell has proved a great success, being well attended by the profession. The next course (free) will commence in October next, and the dates and times will be duly announced in our columns. The Out-patient Department is to be rebuilt immediately. (See advt.)

One of the oldest institutions of the kind is the Western Skin Hospital (Welbeck Street, W.), which was started as long ago as 1851. The practice of the hospital is open to students and practitioners. Students of this specialty have also the "London Skin Hospital," in Fitzroy Square, with seven beds and an out-patient department of over 1,400. There is also the Stamford Street Skin Hospital, in the southern part of the Metropolis, with 10 beds and an out-patient department of 5,600, so that the students' needs in this direction are well catered for.

**LONDON TEMPERANCE HOSPITAL.**—The hospital contains 110 beds, and is conducted as its name implies on non-alcoholic principles by an excellent staff. The medical and surgical practice is open to students and practitioners. Appointments (vacancies for which are advertised in the medical journals): Surgical and medical registrars, resident medical officer, and one assistant resident medical officer.

**METROPOLITAN HOSPITAL,** Kingsland.—This was until recently known as the Metropolitan Free Hospital, is situated in the north-eastern district of the Metropolis, and contains 160 beds. It is a general hospital, with various special departments for the treatment of diseases of the eye, throat, ear, &c.

**TOTTENHAM HOSPITAL,** N.—This hospital contains medical and surgical wards and a ward for children, having in all 73 beds. There are special departments for gynaecological cases, diseases of the eye, ear, throat and nose, and skin diseases. It has now been authorised by the University of London to give certificates of post-graduate study for the M.D. and M.S. degrees.

## METROPOLITAN POST-GRADUATE INSTITUTION.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.**—This institution affords to medical men special facilities for acquiring technical skill, and advancing their medical and scientific knowledge. The building, which is large and commodious, is situated in Chenies Street, Gower Street, and contains lecture and consulting rooms, pathological and clinical laboratories, Röntgen ray room, an ophthalmoscope room, a library and museum, and reading and smoking rooms. *Cliniques*, at which patients are shown, are given every day of the week except Saturday, at 4 p.m. Lectures on Medicine, Surgery, and other allied subjects are delivered on Mondays, Tuesdays, Wednesdays, and Thursdays at 5.15 p.m. Four sessions of practical classes, each lasting six weeks, and a vacation session of three weeks' duration, are held during the year, the subjects taught comprising ophthalmology, otology, clinical microscopy, urinary analysis, gynaecology, laryngology, applied anatomy, nervous diseases, and practical X-ray work. There are, in addition, extra-mural classes in operative surgery, bacteriology, and public health.

A complimentary ticket for three days, admitting to *cliniques* and lectures, is issued to any medical practitioner on personal application at the college. The annual subscription for medical practitioners of either sex, holding qualifications granted in any of H.M.'s dominions—wherever resident—is One Guinea. Full information may be obtained from the medical superintendent, Mr. Hayward Pinch, F.R.C.S.

**WEST LONDON POST-GRADUATE COLLEGE.**—The West London Hospital, Hammersmith, contains 154 beds; the Post-Graduate course was started in 1895. Instruction is given in the out-patient department daily at 2.15 p.m., by assistant physicians and assistant surgeons, and post-graduates can accompany members of the staff on their daily visits to the wards.

*Fees.*—The fee for the hospital practice, including all the ordinary demonstrations and lectures, is £1 1s. for one week; £2 2s. for one month; £4 4s. for three months; £6 6s. for six months; £9 9s. for one year; and £21 for a life ticket; all fees to be paid in advance.

A course of attendance on either the medical or surgical practice alone may be taken out for the fee of £3 3s. for three months. The fee for three months' attendance in any one special department, other than medicine or surgery, is £2 2s.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE.**—At the Tottenham Hospital, N., which is recognised by the University of London for purposes of post-graduate study for the M.D. and M.S. degrees, facilities are afforded to medical practitioners for taking part in the work of an active general hospital, and for attending demonstrations of various branches of medicine, surgery, and gynaecology, with opportunities for clinical instruction in diseases of the eye, ear, throat, nose, diseases of the skin, and dentistry. Clinical lectures and demonstrations are given twice weekly, and include, in addition to the above, instruction in fevers, tropical medicine, psychological medicine, state medicine, electro-diagnosis, and the administration of anaesthetics. Operations are performed every afternoon of the week, except Saturday. The fee for one month's hospital practice is 2 guineas; for three months', 3 guineas, and for a perpetual ticket, 5 guineas. Post-graduates who have attended a three months' course in any department are eligible for appointment as clinical assistants in those departments. Additional information can be obtained from the Dean at the Post-Graduate College, Tottenham.

## PROVINCIAL MEDICAL SCHOOLS.

**BRISTOL UNIVERSITY COLLEGE.—FACULTY OF MEDICINE.**—The lectures and instruction given in the Faculty of Arts and Science of University College, Bristol, are adapted to the various preliminary examinations, and students can complete in Bristol the entire course of study required for the medical and surgical degrees of the University of London and the Royal College of Surgeons of England, and of the Apothe-

caries' Society of London, and for the examination of the Army and Navy Boards. Students of the college are admitted to the clinical practice of those very important and well-equipped institutions, the Bristol Royal Infirmary and the Bristol General Hospital. The infirmary and the hospital comprise between them a total of 470 beds, and both have very extensive out-patient departments, and special departments for the diseases of women and children, and of the eye, ear, and throat, besides large outdoor maternity departments and dental departments. Students of the college also have the privilege of attending the practice of the Bristol Royal Hospital for Sick Children and Women containing 104 beds, and that of the Bristol Eye Hospital, with 40 beds. The total number of beds available for clinical instruction is therefore 614. Very exceptional facilities are thus offered to students for obtaining a wide and thorough acquaintance with all branches of medical and surgical work.

*Appointments.*—At the Royal Infirmary, and also at the General Hospital, clinical clerks and dressers reside in the house in weekly rotation. A pathological clerk is appointed every three months. Also obstetric clerks and ophthalmic dressers. Clinical lectures are given regularly at both institutions.

*Scholarships, Prizes, &c.*—Prizes and certificates of honour are given in University College in all the subjects of the curriculum. There are two entrance scholarships, value £50 and £30 respectively, two Martyrs' memorial scholarships (pathology and morbid anatomy) of £10 each, the Tibbit's memorial prize, value £9, for proficiency in practical surgery, Henry Marshal prize, £12; Clarke Scholarship, £15; Sanders Scholarship, £22 10s.; one gold and silver medal awarded by the committee, and various prizes for clinical work in surgery and medicine.

*Fees.*—School fees for attendance on all courses of lectures, except comparative anatomy, 70 guineas, or 55 guineas. Dental composition fee, 60 guineas. Clinical fees—Surgical practice, one year, 12 guineas; perpetual, 20 guineas. Medical practice, 20 guineas; perpetual medicine and surgery, 35 guineas; clerk or dresser, 5 guineas; obstetric clerk, 3 guineas.

Prospectus and further information on application to the Dean, Professor E. Markham Skerritt.

**SCHOOL OF MEDICINE, THE UNIVERSITY, Leeds.**—This school was originally founded seventy years since as the Leeds Medical School. The building, erected on a site contiguous to the infirmary, and opened six years ago, contains one of the finest dissecting rooms in the Kingdom, extensive laboratories for physiology and pathology, with the most recent improvements in fittings and apparatus, ample lecture-room accommodation, a large library, and separate museums for pathology and anatomy. Professors and lecturers are attached, and the clinical teaching is given by the physicians and surgeons attached to the infirmary. Ophthalmic demonstrations and demonstrations of skin diseases are given in the infirmary by surgeons in each department, where also are obtainable various clinical clerkships, dresserships, and other appointments; and an extern maternity charity is attached, at which the necessary attendance at labours can be taken; besides the infirmary there is a large dispensary, a large hospital for infectious diseases, and a hospital for women and children, all of which are open to students of the school.

*Scholarships, Prizes, &c.*—(1) A Gilchrist scholarship of £50 a year for three years is awarded annually. (2) A University scholarship of £25 (awarded annually). (3) An entrance scholarship of 64 guineas. There are also a Hardwick prize in clinical medicine, a McGill prize in clinical surgery, each of the value of £10, and Thorpe prizes of £10 and £5 in forensic medicine and hygiene, and a Scattergood prize in midwifery, besides silver and gold medals and other class prizes. The composition fee for attendance upon all the required courses of school lectures is 64 guineas for University students who have attended the preliminary scientific courses, and the same for non-University students, exclusive of chemistry and biology.

At the General Infirmary, containing 447 beds, the perpetual fee for medical and surgical practice and clinical lectures is £42 in one sum, or two instalments of £22 each. These fees are not included in the composition fees for lectures, and are payable separately.

A scholarship of £42 to cover the cost of medical and surgical practice is offered annually by the Infirmary.

**MANCHESTER.**—THE MANCHESTER UNIVERSITY SCHOOL OF MEDICINE.—The medical school buildings, which include large laboratories, dissecting-rooms, library and reading-rooms, are on the most modern principles, and students wishing to engage in anatomical, physiological, or pathological research will find excellent opportunity for study in the complete and well-furnished laboratories. Hospital practice is taken out at the Royal Infirmary, which contains 300 beds. The Cheadle Lunatic Asylum, St. Mary's Hospital, the Southern Hospital, and other special hospitals also afford teaching facilities of great importance.

*Appointments.*—The following appointments are made in connection with the Manchester Royal Infirmary:—Surgical registrar, at £80 per annum; a pathological registrar, at £100 per annum; a medical registrar, at £70 per annum; two assistant medical officers, each at £50 per annum; a director of the Clinical Laboratory at £75 per annum; an assistant director of the Clinical Laboratory at £50 per annum; a resident medical officer at the Convalescent Hospital, Cheadle, one year, £150 per annum; resident medical officer, one year, £150; and an assistant at £80 per annum; resident surgical officer, one year, £150 per annum; two chloroformists, annually, at £50; two house surgeons and one house physician are appointed every three months for a term of six months; a resident assistant at the Convalescent Hospital, Cheadle, appointed every six months, and other appointments.

*Scholarships.*—Dalton entrance scholarships, £40 per annum for two years; Cartwright entrance scholarship, £35 per annum for three years; Hulme entrance scholarships, three of £35 per annum for three years; Rogers entrance scholarship, £40 per annum for two years; Seaton entrance scholarship, £40 per annum for two years; James Gaskill entrance scholarship, £40 per annum for two years; Kay Shuttleworth (Sir Jas. Philips) scholarship, £30 per annum for three years; Theodore's modern languages exhibition, £15; Honorary Research Fellowships; Entrance scholarships in Medicine, £100 (towards College and Infirmary fees); Manchester Grammar School scholarships, three of £25 per annum for three years; Turner scholarship of £20 to students who have completed four years of study in the University; Platt physiological scholarships, two of the value of £50 each, tenable for two years, open to students between the ages of 18 and 25; Platt biological scholarship, £50; one Professor Tom Jones exhibition in anatomy of £25; one Professor Tom Jones memorial surgical scholarship of £100, awarded triennially; two Platt exhibitions, £15 each, for first and second year's students in physiology; Sidney Renshaw physiological exhibition, £15; Dumville surgical prize, £15, at the end of the winter session; two Dauntsey medical entrance scholarships, value £35, tenable for one year; John Henry Agnew scholarship in diseases of children, value about £30, awarded annually; a Gilchrist scholarship of £50 per annum tenable for three years, awarded to the candidate standing highest in the first division of the Matriculation examination of the University; the Bradley memorial scholarship, £20, in clinical surgery is offered annually in the summer session to candidates who must be fourth year students; one medical and one surgical clinical prize are also offered annually.

*Fees.*—Composition fee, £70, in two sums of £35 each. Hospital practice: composition fee, £42, or two instalments of £22 each.

*Dental Fees.*—Composition fee, £50, payable in two sums of £25 each. Hospital practice, £21.

**UNIVERSITY OF DURHAM COLLEGE OF MEDICINE,** Newcastle-on-Tyne.—A very commodious and ornate

new building has been erected here at a cost of about £31,000. The Royal Infirmary, at which clinical instruction is obtained, contains 280 beds. Pathological demonstrations are given as opportunity offers. Practical midwifery can be studied at the Newcastle Lying-in Hospital. Opportunities for practical study are also afforded by the Dispensary, City Infectious Diseases Hospital, Eye Infirmary, and at the Northumberland County Lunatic Asylum.

*Appointments.*—Assistant demonstrators of anatomy receiving each an honorarium; prosectors for the professor of anatomy; assistant demonstrators of physiology and pathology; assistants to the dental surgeon, clinical clerks, and dressers are appointed at regular intervals. One year's attendance at the College is required on the part of candidates for the degrees in medicine of the University of Durham.

*Scholarships, &c.*—University scholarships, value £100, for proficiency in arts, awarded annually at the beginning of winter session to full students in their first year only. The Dickinson memorial scholarship (value, the interest of £400 with a gold medal) for medicine, surgery, midwifery, and pathology, open to full students who have passed the primary examination of a licensing body. The Tulloch scholarship, interest of £400 annually, for anatomy, physiology, and chemistry. The Charlton memorial scholarship, interest of £700 annually, open to full students entered for the class of medicine, at end of the fourth or fifth winter. The Gibb scholarship, interest of £500 annually, for pathology, at end of summer session. Goyder memorial scholarship in clinical medicine and clinical surgery, proceeds of £325 annually. The Luke Armstrong memorial scholarship, interest on £680. The Stephen Scott scholarship in surgery, interest on £1,000. The Heath scholarship in surgery (the next award will be in 1906); the interest on £4,000 is awarded every second year. The Gibson prize in midwifery and diseases of women and children; the interest on £225 is awarded yearly. At the end of the session a prize of books is awarded in each of the regular classes.

*Fees.*—(a) A composition ticket for lectures at the college may be obtained—1. By payment of 72 guineas on entrance. 2. By payment of 46 guineas at the commencement of the first sessional year and 36 guineas at the commencement of the second sessional year. 3. By three annual instalments of 36, 31, and 20 guineas, respectively, at the commencement of the sessional year. (b) Fees for attendance on hospital practice: For three months' medical and hospital practice, five guineas; for six months, eight guineas; or by three instalments at the commencement of the sessional year, viz., first year, 12 guineas; second year, 10 guineas; third year, six guineas; or by two instalments, viz., first year, 14 guineas; second year, 12 guineas.

**SHEFFIELD UNIVERSITY COLLEGE MEDICAL DEPARTMENT.**—The medical department contains a medical library, good class-rooms, an excellent anatomical department, and every provision for medical education under the most modern principles. The Favell laboratory of physiology consists of a lecture and demonstration theatre, students' laboratory, preparing room and galvanometer room, all of which are equipped with the most modern apparatus. The pathology department is in a separate temporary building. It contains a pathological museum and laboratory, and a bacteriological laboratory, which has been completely equipped through the generosity of "A Sheffield Citizen." The course of lectures and instruction is adapted to meet the requirements of the various examining bodies. Full courses of instruction required for the D.P.H. are given. The dental department is recognised by the examining bodies. Students at this college obtain medical and surgical practice at the Royal Infirmary, containing 247 beds, and also at the Sheffield Royal Hospital, containing 160 beds. The fees for attendance, £6 6s. each for medical and surgical practice during the winter session, and for three months £3 3s. each. Perpetual fee for medical and surgical hospital practice in a single payment of £45, or in two payments, viz., £26 on entrance, and £22 within twelve months



herwards. Students are also admitted to the practice of the Jessop Hospital for Diseases of Women (80 beds), the City Fever Hospitals, and to the South Yorkshire Tubercular Asylum at Wadsley. The winter session will commence on October 3rd. The building of the new college for departments of Arts, Science, and Medicine, is in active progress and will be ready for occupation in October, 1905. The site adjoins Weston Park and is within easy distance of the hospitals.

**Scholarships, &c.**—An entrance scholarship of the value of £110 is annually awarded to the best candidate of sufficient merit in mathematics, elementary physics, inorganic chemistry, Latin, English.

Composition fee, 60 guineas, or in two instalments of 5 guineas and 30 guineas, for lectures and practical classes required by the Examining Board in England.

The Kaye scholarship, for second year's students, natives of Sheffield, is awarded annually, under certain regulations. Prizes for clinical medicine and clinical surgery: prizes in books and certificates awarded annually.

**UNIVERSITY COLLEGE, CARDIFF, SCHOOL OF MEDICINE.**—This college, which is one of the colleges of the University of Wales, has since its foundation, in 1883, prepared students for the Preliminary Scientific examination of the University of London, and for the corresponding examinations of other licensing bodies. In 1893 Chairs of Anatomy and Physiology and a Lectureship in Materia Medica and Pharmacy were established, making it possible for students of medicine to spend three out of the five years of prescribed study at Cardiff. Arrangements with the managing committee of the Cardiff Infirmary give students of the College the privilege of attending this large and well-ordered hospital, which is situated within five minutes' walk of University College. Many students, especially from Wales and Monmouthshire, avail themselves of the opportunities thus afforded to pursue the earlier part of the medical curriculum near home. All classes are open alike to both men and women students over sixteen years of age. The courses of instruction given at Cardiff are recognised as qualifying for the examinations of the Universities, Royal colleges, and other licensing bodies of Great Britain and Ireland. Having spent two or three years in study at Cardiff, and having passed the examinations in these years, a student may proceed to London or elsewhere and complete his qualifying course for a University degree or for a college diploma.

Students preparing for the first and second examinations of the Conjoint Board for England, or for the corresponding examinations of the Conjoint Board for Scotland, or for those of the Society of Apothecaries, may compound for their classes by paying a single composition fee of £41 10s., or by paying £20 and £24 10s. at the beginning of their first and second years respectively. Those preparing for the preliminary scientific and intermediate examination in medicine of the University of London may compound for their three years' instruction at Cardiff by paying a single composition fee of £57 10s., or by paying £13 13s., £28, and £21 at the beginning of their first, second and third years respectively.

In 1899 a department of Public Health was established, and lecturers in bacteriology and in public health and hygiene were appointed. Medical men preparing for a diploma in Public Health and Hygiene can attend complete courses of lectures and laboratory instruction in this department. These courses are recognised by the University of Cambridge, by the Royal Colleges of Physicians and Surgeons, and by Victoria University.

A course of lectures to midwives, adapted to the requirements of the Central Midwives' Board, under the Midwives' Act, will be commenced early in October, 1904. The lectures will be suitable both for pupil-midwives and practising-midwives, as well as for nurses who desire to enter for the examination for certification under the Act.

**Scholarships, &c.**—The attention of students about to matriculate is drawn to the numerous entrance scholarships for exhibitions which are offered at the college for competition in September, most of which

may be held by medical students. Full particulars of the examination for these may be obtained from the Registrar.

**LIVERPOOL ROYAL SOUTHERN HOSPITAL.**—The clinical school of this hospital is situated within convenient distance of the Liverpool University, and affords every facility for clinical and pathological study. The hospital contains 200 beds, and in addition to the general medical and surgical cases attention is devoted to the diseases of women and children. There is a special ward for tropical diseases in connection with the University laboratories.

The medical and surgical staff visit the wards daily, and the ward instruction is supplemented by weekly clinical lectures. Additions have been made to the teaching staff so that students may now obtain instruction in diseases of the eye, ear and throat. Demonstrations in the use of the X-ray apparatus are given at intervals. There is an excellent pathological department, with laboratory attached, where demonstrations are arranged for and regular instruction is given in practical pathology. The practice of St. George's Hospital for Diseases of the Skin is free to students, and thus ample opportunity is afforded for acquiring a knowledge of dermatology. In addition to the clinical clerkships which are allotted to the students the resident posts of ambulance officers are given to the students whom the board may think most suited to hold them every three months. The Alexander Fellowship in Pathology of £100 a year is open to students of this school; three prizes of £5 each are also awarded to the gentlemen who present the best taken series of medical and surgical cases. *Fees*: Perpetual, £26 5s.; one year, £10 10s.; six months, £7 7s.; three months, £4 4s.

There are rooms for a limited number of resident students; terms (exclusive of fee for hospital practice), £15 15s. per quarter. The practice of the hospital is recognised by all examining bodies.

**LIVERPOOL SCHOOL OF TROPICAL MEDICINE.**—This school, which has for its object research into Tropical Diseases and Improvement in Tropical Sanitation, was founded in Liverpool in 1899 by Sir Alfred Jones, K.C.M.G., who is the chairman of the school. The research work of the school is carried on at the Johnston Laboratories, in Liverpool University. The clinical work is carried on at the Royal Southern Hospital. A special feature of the work of the Liverpool School of Tropical Medicine has been the despatch of a large number of important medical expeditions to various places in the tropics, especially West Africa. Although the School has only been in existence for a short time it has already sent over a dozen of these expeditions. In addition, the School has issued a number of valuable publications and monographs on subjects connected with tropical diseases, which can be obtained from Messrs. Williams and Norgate. The Duke of Northumberland, K.G., and Mr. William Adamson are Vice-Chairmen of the School, and the following is the Staff:—The Sir Alfred Jones Professor of Tropical Medicine, Major Ronald Ross, C.B., F.R.S., F.R.C.S.; Walter Myers Lecturer, Dr. J. W. W. Stephens, M.D.; Walter Myers Fellow, Dr. J. E. Dutton; Assistant Lecturers, Dr. A. S. Grünbaum, Dr. Fielding Ould, Dr. Balfour Stewart, Dr. H. R. Christy, A. H. Milne, M.A. (Cantab.), Hon. Secretary.

**The following are the principal provincial hospitals having the greatest number of beds, to which students are admitted where clinical instruction can be obtained, but to which there is no medical school attached:—**

**BATH ROYAL UNITED HOSPITAL.**—This is a well-appointed hospital in the West of England, with 130 beds, at which students can obtain clinical instruction. The hospital is recognised by the Colleges, and is licensed for dissection. It contains also an excellent museum and library. Fee for six months' attendance, five guineas; twelve months', ten guineas.

**BRADFORD INFIRMARY.**—The hospital contains 230 beds. Non-resident pupils are received—and abundance of clinical material is obtainable. One year's

attendance is recognised by the Examining Boards. Fee, perpetual, £10 10s.

**BRIGHTON SUSSEX COUNTY HOSPITAL** contains 190 beds. It is recognised by the College of Surgeons and by the Conjoint Board. Out-pupils are admitted to the clinical teaching and the classes at a fee of £21 for two years.

**LIVERPOOL NORTHERN HOSPITAL** contains 155 beds. Clinical instruction is given by the staff during the summer and winter sessions. Clinical clerkships and dresserships are open to all students without additional fees. Fees for hospital attendance: Perpetual, £26 5s.; one year, £10 10s.; six months, £7 7s.; three months, £4 4s.; practical pharmacy, £2 2s.

**NORFOLK AND NORWICH HOSPITAL**.—This hospital is recognised by the Colleges, and contains 220 beds. Fees, £10 10s. for six months, £15 15s. for twelve months' medical and surgical practice. Pupils, resident and non-resident, are admitted.

**NORTHAMPTON GENERAL INFIRMARY**.—The number of beds is 163. Out-pupils are received, and have every opportunity of acquiring a practical knowledge of their profession. Instruction is also given in anatomy and materia medica and practical pharmacy. Non-resident pupils are taken at a fee of £10 10s.

**ROYAL BERKSHIRE HOSPITAL**.—The town of Reading, at which this hospital is situated, has a very large working-class population, and excellent opportunities for clinical instruction in the wards and extensive out-patient department are afforded here. It contains a splendid library, in which the Reading Pathological Society holds its meetings.

**THE ROYAL HOSPITAL, PORTSMOUTH**.—The hospital is a preparatory school of medicine and surgery, and the attendance of pupils is recognised by the Examining Boards. The number of beds is 150. The fees being the same as at all similar institutions.

**ROYAL DEVON AND EXETER HOSPITAL, Exeter**.—The hospital contains 218 beds (including special children's wards), and has a good library, museum, dissecting room, and post-mortem room. Attendance on the practice of this hospital qualifies for all the Examining Boards. Arrangements can be made by which students can attend midwifery on application to the House Surgeon.

**WOLVERHAMPTON GENERAL HOSPITAL**.—The hospital contains 230 beds, attendance at this hospital being recognised by all the Examining Boards. Pupils are trained in clinical work by the medical and surgical staff. Fees: Six months, £6 6s.; twelve months, £12 12s.; perpetual, £21.

#### THE ENGLISH UNIVERSITIES.

The English Universities are eight in number, viz., Oxford, Cambridge, London, the Victoria, Durham, Liverpool, Leeds and Birmingham. The choice of a University is usually determined by social, geographical, and financial considerations. Evidently students whose parents are able and willing to incur the necessary expense would do well to select one or other of the ancient Universities, since their degrees confer upon their holders a status not accorded by the public to the degrees of more modern educational institutions. To those less favoured by fortune, but blessed with energy and a fair share of intelligence, the London University offers ample scope, and its degrees are recognised as the outward and visible sign of high professional attainments. A capable and industrious student, however, may equally well lay the foundations of success in one of the newer provincial universities.

#### OXFORD.

There are two degrees in medicine, B.M. and D.M., and two degrees in surgery, B.Ch. and M.Ch. The B.M. and B.Ch. degrees are granted to those members of the University who have passed the second (B.M.) examination. Graduates in Arts, B.A., are alone eligible for these degrees. In order to obtain the degrees of B.M. and B.Ch., the following examinations must be passed:—1. Preliminary: Subjects:—

Physics, chemistry, zoology, and botany. 2. Professional (a) First examination (held twice a year): Subjects:—Organic chemistry, unless the candidate has obtained a first or second class in chemistry in the Natural Science School; Human physiology, unless he has obtained a first or second class in animal physiology in the Natural Science School; Human anatomy; Materia medica with pharmacy. (b) Second examination: Subjects:—Medicine, surgery, midwifery, pathology, forensic medicine with hygiene. The approximate dates of the examinations are as follows:—Preliminaries:—Physics, and chemistry, December and June; Zoology and botany, December and March; Professional (First and Second B.M.), June and December.

The degree of D.M. is granted to Bachelors of Medicine of the University who have entered on their thirty-ninth term on their presenting a dissertation approved of by the appointed professors and examiners.

The degree of M.Ch. is granted to Bachelors of Surgery of the University who have entered their twenty-seventh term, who are members of the surgical staff of a recognised hospital, or have acted as dresser or house surgeon in such a hospital for six months, and who have passed an examination in surgery, surgical anatomy, and surgical operations. This examination is held annually, in June.

The First examination for the degrees of B.M. and B.Ch. may be passed as soon as the Preliminary Scientific examinations have been completed. The subjects of this examination may be presented separately or in any combination or in any order, provided anatomy and physiology be offered and passed together.

In the Second Examination candidates are allowed to present themselves in Pathology, and also in Forensic Medicine at separate Examinations at any time after the First Examination has been passed; but no candidate is permitted to enter for the Examinations in Medicine, Surgery, and Midwifery until he has attained the twenty-fourth term from his matriculation—i.e., six years.

*Diploma in Public Health*.—An examination is held yearly in Michaelmas Term. The first part comprises the application of Chemistry and Physics to General Hygiene. The second part comprises the following subjects:—General Pathology, with special relation to Infectious Diseases; the Laws relating to Public Health; Sanitary Engineering; Vital Statistics. Both parts may be taken together at the same Examination, or they may be taken at separate Examinations: but no one is deemed to have satisfied the Examiners in Part II. unless he has satisfied the Examiners in the subjects of Part I. A diploma is issued to every candidate who has passed in both parts of the Examination, but no Diploma or Certificate is given under any other circumstances. Candidates must have their names on the "Medical Register" and must have satisfied all the Rules of the General Medical Council of the United Kingdom relating to the admission of Candidates for Diplomas in Public Health which are in force at the time.

More detailed information may be obtained from the "Examination Statutes" with the "Regulations" for the current year, published annually in June at the Clarendon Press Depot, price 1s.

#### CAMBRIDGE.

At the University of Cambridge five years of medical study are required for the M.B. and B.C. degrees. The candidate must have resided nine terms (three years) in the University, and have passed the "previous" examination in classics and mathematics. There are three examinations: The first in (1) chemistry and physics, and (2) biology; the second in human anatomy and physiology; and the third in (1) pharmacology and general pathology, (2) in surgery, midwifery, and medicine. The first and the third examinations are divided into two parts, which can be taken separately. Subsequently to the third examination an Act has to be kept which consists in reading an original thesis, followed by an oral examination on the subject of the thesis. As the subjects for the examination for the degree in surgery are included in the third examination

for the M.B. degree, candidates are admitted to the degree of Bachelor of Surgery on passing the third examination for Bachelor of Medicine.

The M.D. degree may be taken three years after the M.B. An Act has to be kept, including the presentation of an original thesis, with oral examinations and an essay to be written extempore. There is also the degree of Master of Surgery, for which the candidate, having already passed for B.C., or being M.A., has otherwise qualified in surgery, has to pursue extra study in surgery, and has a special examination or submits original contributions of merit to the science or art of surgery. The yearly expenditure of a student who keeps his term by a residence in a college is from £150 to £200 a year. This, however, may include all payments to the University and the College—all fees as well as clothes, pocket money, travelling expenses, &c. Non-collegiate students have only to pay the University fees, which are not large. They lodge and board as they like; their expenses, therefore, are entirely in their own hands.

The University degree grants a diploma in public health without the necessity of residence, the examination being in so much of State Medicine as is comprised in the functions of officers of health, and subject to the latest requirements of the General Medical Council. These examinations are held in Cambridge the first week in April and October. Candidates, whose names must be on the "Medical Register" of the United Kingdom, and need not be members of the University, should send in their applications to the Secretary of the State Medicine Syndicate a fortnight in advance. Every candidate who has passed both parts of the examination to the satisfaction of the examiners will receive a testimonial testifying to his competent knowledge of the subjects comprised in the duties of a medical officer of health.

There is also a special examination in Tropical Medicine and Hygiene, held annually in August. It is open to qualified practitioners under certain conditions as to previous study and experience. Successful candidates receive a University Diploma.

An abstract of all Regulations may be obtained upon sending a stamped directed envelope to the Assistant Registrar, Cambridge. Full information is contained in the University Calendar.

#### UNIVERSITY OF LONDON.

The Medical Faculty grants the degrees of Bachelor of Medicine and Surgery, Doctor of Medicine and Master in Surgery. Under the new regulations the students are divided into "Internal" and "External." An internal student is one who has matriculated at the University and is studying in a school approved by that body, or under the teachers of the University. An external student is one who has adopted an alternative course of study. The regulations differ somewhat in their application to the two groups of students. We only propose to deal with them as they affect *internal* students, since the special information required by the others had best be obtained direct from the Registrar. Under no circumstances will a student be admitted to the final examination for a degree until at least three years has elapsed since matriculation or other examination entitling to registration as a medical student.\*

The *Matriculation Examination* will take place three times in each year—in January, June (or July), and September. Application for admission to it must be made on a special form about six weeks beforehand, and the candidate must have completed his 16th year at the date of the examination. Candidates must show a competent knowledge of five subjects, among which *must* be English and elementary mathematics. The other three (one of them a language) may be selected from the following:—Latin, Greek, French, German, Arabic,\* Sanscrit,\* Spanish,\* Portuguese,\* Italian,\* Hebrew,\* Ancient History, Modern History, Logic, Physical and General Geography, Geometrical and Mechanical Drawing, Mathematics (more advanced than in the compulsory examination), Elementary Mechanics, Elementary Chemistry, Elementary Biology

\* May obtain registration as Internal or External students on presentation of documentary evidence as to their condition and a payment

(Botany), Elementary Biology (Zoology),\* Elementary Physics, Heat, Light, and Sound, Electricity, and Magnetism. Candidates who desire to be examined in the subjects against which an asterisk is affixed must give at least two months' notice.

The *Preliminary Scientific Examination* will take place twice in each year, in January and July. It will consist of papers in chemistry, biology, and physics, and there will be a practical examination in each subject. Examiners will also be at liberty to test candidates *viva voce*. A student may present himself for examination in each of the three subjects, separately or in all at the same time. Part I. of this examination includes papers in inorganic chemistry, physics, and biology, with practical examinations; Part II. is an examination in organic chemistry.

The *Intermediate Examination in Medicine* will take place twice a year, January and July. Candidates must have passed the Preliminary Scientific Examination at least two years previously. The subjects of examination are Anatomy, Physiology and Histology, and Pharmacology, including *Materia Medica*. Candidates who have failed in one subject only at this examination may offer themselves for re-examination in that subject, if permitted to do so by the examiners. Three scholarships, one of the value of £40 in Anatomy, another of the same amount in Physiology, and one of £30 in Pharmacology may be awarded by the examiners to any candidate who has passed the whole of the examination at one time.

The *Final M.B., B.S., Examination* will take place twice a year, in October and May. No candidate will be admitted to this examination unless he has completed the course of study prescribed in the schedule or in less than two academic years from the date of passing the Intermediate Examination in anatomy and physiology.

The subjects of the examination are Medicine (including Therapeutics and Mental Diseases), Pathology, Forensic Medicine and Hygiene, Surgery, and Midwifery and Diseases of Women. The subjects may be divided into two groups, one of which shall comprise Medicine, Pathology, Forensic Medicine and Hygiene; and the other Surgery, Midwifery and Diseases of Women. Either group may be taken first at the option of the candidate, or the groups may be taken together.

Only candidates who show a competent knowledge of all the subjects comprising a group will be passed. The examiners will be empowered to recommend the award of a University Medal to the candidate who has most distinguished himself in the whole examination.

*Doctor of Medicine.*—The examination for the degree of Doctor of Medicine will be held twice in each year, in December and July. Every candidate must have passed the examination for the M.B., B.S., of this University. Candidates may present themselves for examination in one of the following branches: (1) Medicine, (2) Pathology, (3) Mental Diseases, (4) Midwifery and Diseases of Women, (5) State Medicine; and if they wish, may pass also in another branch at a subsequent examination. Candidates for Branches 1 to 4 who have taken honours at the M.B., B.S., examination in the subject in which they present themselves for the M.D. degree, or who, subsequently to taking the M.B., B.S., have conducted a piece of original work approved for the purpose by the University, or have had special experience approved by the University, may present themselves for the M.D. examination one year after taking their Bachelor's

of £2: Graduates of such British, Colonial, and foreign Universities as are approved by the Senate for that purpose, and those who have passed all the examinations required for a degree in those Universities, also women who have obtained Tripos certificates granted by the University of Cambridge, and women who have obtained certificates showing that, under the conditions prescribed by the Delegacy for Local Examinations at Oxford, they have passed the Second Public Examination of that University or have obtained honours in the Oxford University Examination for Women in Modern Languages, and students who hold the Scotch School Leaving Certificate, having passed on one and the same occasion, in the Higher or Honours Grade in all the subjects required by the regulations for the Matriculation Examination, and those who hold the Zeugnis der Reife from a Gymnasium or Realgymnasium within the German or Austrian Empire, or the Maturitäts-Zeugnis of a Swiss Gymnasium or Oberrealschule, or the Eidgenössische Maturitäts-Zeugnis of Switzerland.

degree. Other candidates must show that they have taken the degree of M.B., B.S., not less than two years previously; and as regards candidates in Branches 1 to 4, that subsequently to taking that degree they have held for at least six months a resident or non-resident medical hospital appointment, or that they have been in qualified practice for not less than five years, while candidates in Branches 2 and 3 must show that they have held in the one case a pathological and in the other an asylum appointment. In each branch there will be (1) two papers on the special subject of the branch; (2) a clinical examination; (3) an essay to be written on one of two given subjects connected with the branch. In Branch 1 there will also be a paper on pathology, and in Branches 2, 3, and 4 a paper in medicine, while in Branch 2 a laboratory examination will be substituted for the Clinical Examination held in the other branches.

Candidates in Branch 5 (State Medicine) must show that they have taken the degrees M.B., B.S. not less than two years previously, and that subsequently to taking those degrees they have had (1) six months' practical instruction in an approved laboratory; (2) six months' practical instruction from a medical officer of health, of which three must not coincide with the laboratory work, and three months' practice at a hospital for infectious diseases. The interval between passing the M.B., B.S. and proceeding to the M.D. State Medicine may be reduced to one year, subject to conditions corresponding to those affecting Branches 1, 2, 3, and 4.

*Master of Surgery.*—The examination for the degree of Master in Surgery will take place twice in each year, commencing on the same dates as the foregoing, and the general regulations already quoted with regard to the M.D. will practically apply to it, surgery being substituted for medicine. The examination will consist of (1) two papers on surgery (one of which may be a case for commentary); (2) an essay to be written on one of two subjects which may be selected from any branch of surgery; (3) two papers on surgical pathology and surgical anatomy; (4) a clinical examination; (5) operations on the dead body; (6) a *viva voce* at the discretion of the examiners. Competent knowledge in every subject of the examination must be shown in order to pass.

For the M.S. degree and all branches of the M.D. a candidate is at liberty to forward a thesis or copies of published works embodying the result of independent research in the subject in which he presents himself for a degree and also any printed contributions to the advancement of professional knowledge published either separately or conjointly. If the examiners consider such thesis or works of sufficient merit they are empowered to exempt a candidate partly or entirely from examination in the subject to which such work refers. They also have power to award a University Medal to the candidate who at the examination in any branch passes with most distinction.

*Fees.*—For the Matriculation: £2 and £1 on re-examination in any one subject, and £2 for more than one. Preliminary Scientific Examination: £5 for each entry to the whole examination, and £2 for each subject when less than the whole examination is taken at one time. Intermediate Examination: £10 for each entry to the whole examination, and £5 for examination in one subject. M.B., B.S. Examination: £10 for each entry to the whole examination, and £5 for examination or re-examination in either group. M.D. and M.S. Examinations: £20 for each entry.

#### UNIVERSITY OF DURHAM.

One diploma and six degrees in Medicine and Hygiene are conferred, *viz.*, the degrees of Bachelor in Medicine, Bachelor in Surgery, Master in Surgery, Doctor in Medicine, Bachelor in Hygiene, and Doctor in Hygiene, and Diploma in Public Health. These degrees are open to both men and women.

For the degree of Bachelor in Medicine (M.B.) there are four professional examinations. The subjects for the first are: Elementary anatomy and elementary biology, chemistry, and physics. For the second: Anatomy, physiology, materia medica, therapeutics, and pharmacology. For the third: Pathology, medi-

cal jurisprudence, public health, and elementary bacteriology; and for the fourth: Medicine, clinical medicine and psychological medicine, surgery and clinical surgery, midwifery, and diseases of women and children.

It is required that one of the five years of professional education shall be spent in attendance at the University College of Medicine and the Royal Infirmary, Newcastle-upon-Tyne. First and second year students (dating from registration) are not required to comply with the regulation regarding attendance on hospital practice.

Candidates who have passed the First and Second Examinations of the University will be exempt from the First and Second Examination of the Conjoint Board.

For the degree of Bachelor in Surgery (B.S.) every candidate must have passed the examination for the degree of Bachelor of Medicine of the University of Durham, and must have attended one course of lectures on operative surgery, and one course or regional anatomy. Candidates will be required to perform operations on the dead body, and to give proof of practical knowledge of the use of surgical instruments and appliances.

For the degree of Master in Surgery (M.S.) candidates must not be less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek. In case they shall not have passed in this subject at the Preliminary Examinations in Arts for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they can proceed to the higher degree of M.S. They must also have obtained the degree of Bachelor in Surgery of the University of Durham, and must have been engaged for at least two years subsequently to the date of acquirement of the degree of Bachelor in Surgery in attendance on the practice of a recognised hospital, or in the naval or military service, or in medical or surgical practice.

For the degree of Doctor in Medicine (M.D.) candidates must be of not less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek. In case they shall not have passed in this subject at the Preliminary Examinations in Arts for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they proceed to the higher degree of M.D. They must also have obtained the degree of Bachelor of Medicine of the University of Durham, and must have been engaged for at least two years, subsequently to the date of acquirement of the degree of Bachelor of Medicine, in attendance on the practice of a recognised hospital or in the naval or military services, or in medical or surgical practice.

Each candidate must prepare an essay, which must be typewritten, based on original research or observation, on some medical subject selected by himself, and approved by the Professor of Medicine, and must pass an examination thereon, and must be prepared to answer questions on the other subjects of his curriculum, so far as they are related to the subjects of the essay.

For regulations for degrees in Hygiene and for the diploma in Public Health see Calendar 1904-5.

Candidates for any of the above degrees must give at least twenty-eight days' notice to the Secretary of the College of Medicine, Newcastle-on-Tyne. In the case of the M.D. (Essay) Examination, candidates must send in their essays six weeks before the date of the examination.

Residence can be had in a separate hostel for female students at moderate inclusive fees for board, &c., particulars of which and any other college information will be given on application to Prof. Howden, Secretary, University of Durham College of Medicine, Newcastle-on-Tyne.

#### VICTORIA UNIVERSITY OF MANCHESTER.

Candidates for degrees in medicine and surgery must attend classes in the University during at least two years.

The degrees in the Faculty of Medicine are Bachelor

of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). All candidates for degrees in medicine and surgery are required to pass the Matriculation Examination, or to have passed such other examination as may from time to time be recognised for this purpose by the University.

The subjects of the Matriculation Examination are—1, Latin; 2, mathematics; 3, mechanics; 4, English and history; 5, one of the following:—(a) French; (b) German; (c) Greek; (d) Italian; (e) Spanish; (f) any other modern language, permission to present which has been obtained from the Joint Matriculation Board. Notice of intention to present either Italian or Spanish must be given to the Secretary, Joint Matriculation Board, Manchester, before March 1st in each year.

Before admission to the degrees of Bachelor of Medicine and Surgery candidates are required to send in the usual certificates of age and study as at the other Universities.

All candidates for these degrees must pass three examinations, namely—the First Examination; the Second Examination; and the Final Examination.

**First Examination.**—The subjects of the examination are, 1, Chemistry; 2, Elementary biology; 3, Physics.

Candidates must have attended, during at least one year, courses of both lectures and laboratory work in each of the above-named subjects.

**Second.**—1, Anatomy; 2, Physiology (including physiological chemistry and histology); 3, Materia medica and pharmacy.

Candidates must have passed the First Examination, and have attended courses of instruction in anatomy (systematic and practical) during two winter sessions and one summer session, in physiology for two winter sessions, in materia medica and pharmacy for one summer session. Candidates may present themselves separately in (a) anatomy and physiology, (b) materia medica and pharmacy.

**Final.**—The examination is divided into two parts, which may be passed separately or on the same occasion, but the first part cannot be taken before the end of the third year, and the second part cannot be taken less than two years after passing Second M.B., or before the fifth year of medical study in accordance with the University regulations. The subjects of examination are as follows: 1, Pharmacology and therapeutics; 2, General pathology and morbid anatomy; 3, Forensic medicine and toxicology and public health; 4, Obstetrics and diseases of women; 5, Surgery, systematic, clinical, and practical; 6, Medicine, systematic and clinical, including mental diseases and diseases of children. Candidates may select as a first part of the examination two or three of the subjects 1, 2, and 3.

The certificates required from candidates at the final examination are practically the same as for the corresponding examination at the London University, and only those who have previously passed the Second Examination are admitted to it. The regulations relating to the M.D. and Ch.M. degrees can be obtained on application to the Registrar.

**Fees.**—Matriculation examination, £2; for any subsequent examination, £1. First Examination, £5; for any subsequent examination, £2. The fees for the Second Examination, for the Final Examination, and for the examination for the degree of Ch.M. are the same as for the First Examination. A fee of £10 is payable on the conferring of the degree of M.D., a fee of £4 on the conferring of the degree of Ch.M.

The Matriculation Examination is held in June, in July (for schools), and about the end of September. The first M.B. and Ch.B. is held in June; also about the end of September. The Second and Final Examinations are held in March and July, the examination for Ch.M. in July only.

#### UNIVERSITY OF BIRMINGHAM.

The University of Birmingham grants degrees of M.B., Ch.B., M.D., Ch.M., and also a B.Sc. in the subject of Public Health. As a rule, in order to obtain

any of these degrees it is necessary that a student shall have passed at least the first four years of his curriculum in attendance upon the classes of the University, but the Senate has power of recognising attendance at another University as part of the attendance qualifying for these degrees.

**Degrees of Bachelor of Medicine and Bachelor of Surgery.**—The student must have passed either the Matriculation Examination of the University or one of the following examinations, which will be accepted in lieu thereof for the present:—(a) The previous examination of the University of Cambridge; (b) Responsions of the University of Oxford; (c) The matriculation examination of any other University in the United Kingdom; (d) The leaving certificate (higher) of the Oxford and Cambridge Boards; (e) The Oxford or Cambridge junior local examination (first or second class honours); (f) The Oxford or Cambridge senior local examination (honours); (g) The College of Preceptors examination for first-class certificate.

Matriculation Examinations are held in June and September each year.

**Degrees of Doctor of Medicine and Master of Surgery.**—At the end of one year from the date of having passed the Final M.B., Ch.B. Examination, the candidate will be eligible to present himself for the higher degrees of either Doctor of Medicine or Master of Surgery or both, the regulations for which may be had upon application to the Registrar. The University also grants a Degree and a Diploma in Public Health, and provides adequate instructions for the same.

**Dental Department.**—The University grants the Degrees of Bachelor and Master of Dental Surgery (B.D.S. and M.D.S.) The whole of the instruction for which may be taken out in the University.

**THE GENERAL AND QUEEN'S HOSPITALS.**—The practices of these hospitals are amalgamated for the purpose of clinical instruction under the direction of the Birmingham Clinical Board, by whom all schedules will be signed and all examinations conducted. The hospitals have a total of upwards of 400 beds. 6,000 in-patients and 80,000 out-patients are treated annually, and many valuable posts are open to students at both.

Further information can be obtained from Professor Windle, Dean, Medical Faculty.

#### UNIVERSITY OF LIVERPOOL.

Students may enter for the degrees of the University of Liverpool, or may study for the degrees and qualifications of the other licensing bodies.

**Hospitals.**—Students may take out their clinical work at the Liverpool Royal Infirmary, or at the United Hospitals Clinical School, which has been formed by the David Lewis Northern Hospital, the Royal Southern Hospital, and the Stanley Hospital. Particulars as to fees, appointments, &c., may be obtained from the Secretaries of these schools. The practice of the Lying-in, Eye and Ear, Women's, Children's, Dental, and Skin Hospitals is also open to students of the Faculty of Medicine.

**Fellowships and Scholarships.**—Fellowships, Scholarships, and Prizes of over £700 are awarded annually. A Holt Fellowship in Pathology and Surgery, of the value of £100 for one year, is awarded annually by the Medical Faculty to a senior student possessing a medical qualification. The successful candidate is required to devote a year to tutorial work and investigation in the Pathological department. A Holt Fellowship in Physiology, awarded under similar conditions, also of the value of £100 for one year. A Robert Gee Fellowship in Anatomy, awarded under similar conditions, of the value of £100 for one year. An Alexander Fellowship for Research in Pathology of the annual value of £100, renewable. A Johnson Colonial Fellowship in Pathology and Bacteriology (£100 a year, renewable). A John W. Garrett International Fellowship in Physiology and Pathology (£100 a year, renewable). An Ethel Boyce Fellowship in Gynaecological Pathology (£100 a year, renewable). A Stopford Taylor Fellowship (£100 a year, renewable) in Dermatological Pathology. A Thelwall Thomas Fellowship (£100 a year, renewable) in Surgical

Pathology. Two Lyon Jones scholarships, of the value of £21 each for two years, are awarded annually—a Junior Scholarship, open at the end of the first year of study to Liverpool University students in the subjects of the first M.B. Examinations, and a Senior Scholarship, open to all students in the school at the end of the second or third year of study, in the subjects of Anatomy, Physiology, and Therapeutics. The Derby Exhibition of £15 for one year is awarded in Clinical Medicine and Surgery in alternate years. Students may compete in their fourth and fifth years. In 1904 the subject will be Clinical Medicine. The Torr Gold Medal in Anatomy, the George Holt Medal in Physiology, the Kanthack Medal in Pathology, the Robert Gee Book Prize, of the value of £5, for Children's Diseases, and numerous class prizes are awarded annually.

*Entrance Scholarships.*—Four Robert Gee Entrance Scholarships, of the value each of £25 for one year, are offered annually for competition. The holder is required to take out the Science Course for the University Degree in Medicine.

Communications should be addressed to the Dean, Professor Benjamin Moore, M.A., D.Sc., the University, Liverpool.

### THE ENGLISH COLLEGES.

THE medical corporations in England are the Royal College of Physicians of London, the Royal College of Surgeons of England, and the Society of Apothecaries of London. The two Royal Colleges now co-operate to hold a series of examinations, on passing which the candidate receives the diploma of Licentiate of the Royal College of Physicians (L.R.C.P.), and Member of the Royal College of Surgeons (M.R.C.S.). The Society of Apothecaries grants a complete diploma in medicine, surgery, and midwifery.

#### CONJOINT EXAMINING BOARD IN ENGLAND.

Candidates for the above licences are required to complete five years of professional study at recognised medical schools and hospitals, after passing the preliminary examination, of which six months may be spent at an institution recognised by the Board for instruction in chemistry, or one year may be passed at an institution recognised by the Board for instruction in chemistry and biology, to comply with the following regulations and to pass the examinations hereinafter set forth.

*Professional Examinations.*—There are three examinations, each being partly written, partly oral, and partly practical. These examinations will be held in the months of January, April, July, and October, unless otherwise appointed, fourteen clear days' notice before the day on which the examination commences being required, the candidate transmitting at the same time the required certificates.

The subjects of the first professional examination are chemistry and physics, practical pharmacy, and elementary biology. A candidate is allowed to take this examination in three parts at different times. Rejection entails a delay of not less than three months from the date of rejection, and the candidate will be re-examined in the subject or subjects in which he has been rejected. If referred in chemistry or biology, he must produce evidence of further instruction at a recognised institution. Practical pharmacy may be passed at any time during the curriculum. Any candidate who shall produce satisfactory evidence of having passed an examination for a degree in medicine on any of the subjects of this examination conducted at a University in the United Kingdom, India, or in a British Colony, will be exempt from examination in those subjects in which he has passed.

The fees for admission to the first examination are as follows:—For the whole examination, £10 10s.; for re-examination after rejection in Part I., £3 3s.; and for re-examination in each of the other parts, £2 2s.

The subjects of the second examination are anatomy and physiology. Candidates will be required to pass in both subjects at one and the same time. Candidates will be admissible to the second examination at the

expiration of two winter sessions and one summer session (or fifteen months during the ordinary sessions) from the date of registration as medical students, and after the lapse of not less than nine months from the date of passing Parts I. and III. of the first examination.

A candidate referred at the second examination will be required, before being admitted to re-examination, to produce a certificate that he has pursued, to the satisfaction of his teachers, in a recognised place of study, his anatomical and physiological studies during a period of not less than three months subsequently to the date of his reference.

The fees for admission to the second examinations are: £10 10s. for the whole examination, and £6 6s. for re-examination after rejection.

The subjects of the third and final examinations are:—Part I. Medicine, including medical anatomy, pathology, practical pharmacy, therapeutics, forensic medicine and public health. Candidates who have passed in practical pharmacy at the first examination will not be re-examined in that subject at the third examination. Part II. Surgery, including pathology, surgical anatomy, and the use of surgical appliances. Part III. Midwifery and gynaecology. Candidates may take this examination in three parts separately, or they may present themselves for the whole examination at one time.

Fees for admission to the third or final examination are as follows:—For the whole examination, £15 15s.

Part I.—For re-examination in medicine, including medical anatomy, pathology, therapeutics, forensic medicine, and public health, £5 5s.; for re-examination in practical pharmacy (if taken at this examination), £2 2s. Part II.—For re-examination in surgery, including pathology, surgical anatomy, and the use of surgical appliances, £5 5s. Part III.—For re-examination in midwifery and gynaecology, £3 3s.

A candidate referred on the third or final examination will not be admitted to re-examination until after the lapse of a period of not less than three months from the date of rejection, and will be required, before being admitted to re-examination, to produce a certificate, in regard to medicine and surgery, of having attended the medical and surgical practice, or the medical or surgical practice, as the case may be, during the period of his reference; and in regard to midwifery and diseases peculiar to women a certificate of having received, subsequently to the date of his reference, not less than three months' instruction in that subject by a recognised teacher.

#### REGULATIONS FOR COLONIAL, INDIAN, AND FOREIGN CANDIDATES, AND UNIVERSITY CANDIDATES.

Persons holding a Colonial, Indian, or a foreign qualification entitling them to practise medicine in the country of origin, and conferred after a course of study and examinations equivalent to those required by the Royal Colleges, are admissible to the second and third (final) examinations forthwith.

Members of a University in the United Kingdom are, under certain conditions, eligible for admission to the third (final) examination two years after passing at their University in the subjects included in the first and second examinations of the Board.

#### ROYAL COLLEGE OF PHYSICIANS OF LONDON.

*Licentiate.*—Candidates are now subject to the regulations of the Conjoint Examining Board in England.

The following by-laws, amended in conformity with the revised regulations of the Conjoint Examining Board, were re-enacted as follows:—

"Every candidate for the College licence (unless specially exempted) shall be required to produce satisfactory evidence of having passed before the commencement of professional study a preliminary examination on subjects of general education recognised by the College.

"Every candidate shall be required to produce satisfactory evidence of having completed five years of professional study, after passing a recognised preliminary examination before admission to the final examination.

"A candidate shall not be admitted to the second examination until the completion of two winter sessions and one summer session (or 15 months during the ordi-



nary sessions) at a recognised medical school, nor until the expiration of one winter and one summer session after passing Parts I. and III. of the first examination.

"A candidate shall not be admitted to the third (or final) examination till the expiration of five winter and five summer sessions from the date of passing the preliminary examinations and of four winter and four summer sessions after passing Parts I. and III. of the first examination, and of two winter and two summer sessions after passing the second examination."

**Members.**—The membership of the College is granted after examination to persons above the age of 25 years who do not engage in trade, do not dispense medicine, and do not practise in partnership. This diploma is only granted to persons already registered, or who have passed the final examination for the licence.

Medical graduates of a recognised University are admitted to a pass examination, but others must have passed the examinations required for the licence of the College. The examination, which is held in January, April, July, and October, is partly written and partly oral. It is directed to medicine, and is conducted by the president and censors. Candidates under 40, unless they have obtained a degree in arts in a British University, are examined in Latin, and either Greek, French, or German. Candidates over 40 are not so examined, and the examination in medicine may in their case be modified under conditions to be ascertained by application to the Registrar. The fee for the membership is £42, but if the candidate is a licentiate £15 5s. is deducted. In either case £6 6s. has to be paid before examination.

#### ROYAL COLLEGE OF SURGEONS OF ENGLAND.

**MEMBERSHIP.**—The candidates are now subject to the regulations of the Conjoint Board.

**FELLOWSHIP.**—The Fellowship of the College of Surgeons is granted after examination to persons at least 25 years of age, who have been engaged in professional studies for six years. There are two examinations—the first in anatomy and physiology, which may be passed after the third winter session; the second chiefly directed to surgery, which may be passed after six years of professional study. The second examination may be passed before attaining the age of 25, but the diploma is not granted until that age is reached. Candidates for this part of the examination must have passed the final examination of the Conjoint Board in England, and have been admitted members of the College before they can be admitted thereto, except in the case of graduates in medicine and surgery of recognised Universities of not less than four years' standing.

**FEES.**—First examination, £5 5s.; second examination, £12 12s. The total fee payable on admission to the Fellowship is £31 10s., except for members, when the fee is £21. (The examination fees to the extent of £17 17s. count as part of the total fee.) Further information can be obtained on application to the Secretary of the Royal College of Surgeons, Lincoln's Inn Fields, London, W.C.

There are two examinations—primary and final. The primary examination is held quarterly on the first Wednesday, and on the Monday and Tuesday in the same week, in the months of January, April, July, and October. The final examination is held monthly.

#### SOCIETY OF APOTHECARIES OF LONDON.

**PRIMARY EXAMINATION.**—This examination consists of two parts: Part I.—Elementary biology, Chemistry, Chemical physics, including the elementary mechanics of solids and fluids; Heat, Light, and Electricity. Practical chemistry, Materia medica, and Pharmacy. A synopsis indicating the range of the subjects may be obtained on application. Part II.—Anatomy and Physiology and Histology. The examination is held in January, April, July, and October.

The final examination is held monthly, and is divided into Sections 1 and 2.

Section 1 consists of three parts.

Part I. includes: Principles and Practice of Surgery, Surgical Pathology, and Surgical Anatomy, Operative Manipulations, Instruments and Appliances.

Part II. includes: (a) The Principles and Practice of

Medicine, including Therapeutics, Pharmacology, Pathology, and Morbid Histology. (b) Forensic Medicine, Hygiene, Theory and Practice of Vaccination; and Mental Diseases.

Candidates passing either (a) or (b) will not be re-examined therein.

Part III. includes: Midwifery, Gynæcology, and Diseases of New-born Children, Obstetric Instruments and Appliances. Candidates may enter for Parts I., II., and III. together or separately.

Section 1 of the Final Examination, or any part thereof, cannot be passed before the expiration of 45 months from the date of registration as a medical student.

Section 2.—This section consists of two parts.

Part I.—Clinical Surgery.

Part II.—Clinical Medicine and Medical Anatomy. Section 2 cannot be passed before the expiration of the fifth year.

**FEES.**—Primary examination, £10 10s.; final examination, £10 10s.; total fee, £21.

Further information, with particulars as to the course of study and of the certificates required, can be obtained from the Secretary to the Court of Examiners, Apothecaries' Hall, E.C.

This licence is a registrable diploma in Medicine, Surgery, and Midwifery, and qualifies the holder to compete for medical appointments in the Army, Navy, and Indian Services, also for Poor-law, Civil, and Colonial appointments.

The Gillson scholarship in Pathology of the annual value of £90, tenable for one year, is open to Licentiates of the Society and to candidates for the diploma who obtain it within six months of election to the scholarship. An examination in the art of prescribing is held annually, in January, at which the following prizes are awarded:—A gold medal of the value of £6; a silver medal, and a prize of books to the two best candidates.

## Ireland.

### THE IRISH MEDICAL SYSTEM.

THE system of medical teaching in Ireland differs from that in England in important particulars. In London each clinical hospital has its attached medical school, which is fully equipped, and which educates the students of that hospital and very seldom those of any other. In Dublin, on the contrary, the hospitals and schools are entirely separate (except that Sir Patrick Dun's Hospital is officially connected with Trinity College), and a student of any hospital is free to enter for the whole or any part of his course at any school or hospital he pleases. As might be expected, religion, social rank, and locality of residence have their influence in causing certain classes of students to resort to schools and hospitals suitable to their condition. But scholastic or collegiate regulations impose no restrictions as to the place of study, and as the school and hospital fees are paid in detail in Dublin, and not in a lump sum, as in London, the pupil is free to do as he pleases.

#### BOARD AND RESIDENCE.

There is in Dublin no organisation for domestic accommodation of medical students, save for those who are passing through Trinity College, in whose case rooms and "commons" (*i.e.*, dinner) are provided at fixed rates. Those who can afford to pay £6 6s. or £7 7s. per month for their lodging and maintenance may find accommodation in the family of some medical man who receives boarders, in which case they become members of the family for the time being. The majority of Dublin students, however, take a lodging in some economical locality, or they "chum" with some other student for the purpose. It is usual to contract with the lodging-house keeper for board or partial board, but some students cater for themselves.

#### COST OF MEDICAL EDUCATION IN IRELAND.

The cost of obtaining a medical qualification depends to some extent on the qualification sought. In this

connection the following tables may be of use to the prospective student :—

COST OF MEDICAL EDUCATION.	
School of Physic, Dub. Univ. . .	£119 14s.
Royal College of Surgeons School . .	£124 19s.
Catholic University School . .	£124 19s.
Queen's College . . . . .	About £110
COST OF DIPLOMAS OR DEGREES.	
Dublin University : . . . .	£27 (to this must be added £83 4s., the cost of obtaining an Arts degree).
Royal University . . . . .	£15.
Conjoint Royal Colleges . . . .	£42.
Apothecaries' Hall . . . . .	£22 1s.

Thus, the absolute payment will amount to somewhere between £125 and £229 18s., according as the teaching of the Queen's Colleges and the degrees of the Royal University, or the teaching and degrees of Dublin University, are taken. For the Conjoint Colleges the entire cost is £166 19s., taking the minimum mode of payment. So that, assuming that extras or voluntary costs are incurred the total will vary, say, from £170 to £200. "Grinding" usually costs £5 5s. for each of the four examinations, but if a student needs private instruction in special subjects he must pay extra for it.

This sum, or something like it, may be expended by the student or his parent in paying for lectures, &c., and examination fees as they fall due, and there is no difficulty in obtaining the needful information for his guidance if he likes to pay for his course in this fashion. If, on the other hand, he prefers to pay a large sum down, he can "apprentice" himself to a teacher who will undertake all monetary responsibility for his education, and who may be able to give him some special advantage as his own pupil at hospital. This so-called "apprenticeship," is very generally a simple contract for the payment of fees, and involves but little special teaching. All the Dublin schools require fees to be paid in advance.

#### DATE OF ENTRY.

The entry of names and commencement of study in Ireland is supposed to date from the 1st of October in each year, but the session really dates from the 1st of November, and the entry of names may be delayed by the dilatory to the 25th of the same month. It should, however, be recollected that no credit is given for studies or attendance until the entry is regularly made. The student must attend three-fourths of the lectures delivered, and if he loses a fortnight at the beginning he must make up for it afterwards by constant attendance.

The student begins work by attending a recognised medical school each morning at ten o'clock, and occupying his day, to five p.m., between lectures and dissections. His vacations are a fortnight at Christmas and a week at Easter, and he finally returns home at the end of June.

#### PRELIMINARY EXAMINATIONS.

The first act of the student is to pass a preliminary examination, without which he cannot get credit for any medical studies pursued. The next is to commence medical study. This he does by entering for lectures at a medical school. From the school registrar he gets a form of certificate, and his third act is to take it or send it to the Branch Medical Council, 35 Dawson Street, Dublin. He is thereupon placed upon the Register of Medical Students (without fee), and his period of study counts from that date. He must register at the earliest possible moment, or he may lose credit for his work.

The only preliminary examination held specially for medical students is that held conjointly by the Royal Colleges of Physicians and Surgeons, but other examinations, e.g., the public entrance at Trinity College, the matriculation of the Royal University, the Intermediate Education passes in the required subjects, and all other examinations recognised by the General Medical Council are accepted as equivalent.

The subjects of examination as prescribed by the

General Medical Council are as follows :—1. English language, including a specified author, dictation, grammar, and composition ; also parsing and analysis from the book specified. 2. Latin, including grammar, translation from specified authors, and translation of easy passages not taken from such authors. 3. Elements of mathematics, comprising (a) arithmetic, including vulgar and decimal fractions ; (b) algebra, including simple equations ; (c) geometry, Euclid, Books I., II., and III., with easy deductions. 4. One of the following optional subjects :—(a) Greek, (b) French, (c) German.

#### QUALIFICATION IN IRELAND.

The Medical Licensing Bodies of Ireland are four in number, and, as a rule, students gravitate into one or other of five classes :—a. Those who enter Trinity College, and take a full graduation in Arts in addition to their professional degrees. b. Those who take the licence of the conjoint Royal Colleges of Physicians and Surgeons. c. Those who take the licence of the Apothecaries' Hall. d. Those who take their qualifications at the Royal University of Ireland, where graduation in Arts is not necessary. e. Those who pursue their studies in Ireland, but who migrate to London, Edinburgh, or Glasgow for their licences. Almost all these last-named emigrants come from the Queen's Colleges, and the greater number of them from Belfast, while the Dublin students qualify, as a rule, in Dublin.

We do not attempt to give details as to the requisite courses of instruction for degrees or diplomata, as our epitome must necessarily be insufficient for the information of the student, and we can occupy our available space with information more useful to him. The official information upon which students may depend can be obtained by sending a note to the Registrars of the Licensing Bodies or Schools.

The Irish Licensing Bodies are as follows :—

#### THE UNIVERSITY OF DUBLIN.

The University of Dublin grants the degrees of M.B., B.Ch., and B.A.O. to students who have obtained their Arts degree, and who have been for at least five academic years on the books of the Medical School, and the higher degrees of M.D., M.Ch., and M.A.O. to those who have held, or have been qualified to hold, for at least three years, the grade of M.B. and B.Ch. It does not grant degrees to any but full graduates in Arts, consequently its degrees hold the highest rank of social and educational qualifications, and are sought for by those who look forward to occupying the best positions in the profession.

The expense of obtaining the degrees of M.B., B.Ch., and B.A.O. is approximately as follows :—Lectures, £64 11s. 6d. ; Hospitals, £55 13s. ; Degree Fees, £27.—Total, £147 4s. 6d.

The expense of the B.A., amounting altogether to £83 4s., should be added, making the total cost £230 8s. 6d.

In addition to its ordinary qualifications the University grants the following higher degrees :—

*Doctor of Medicine.*—To obtain this the candidate must have obtained the degree of M.B., or have been qualified to have obtained it for three years. He must then read a thesis before the Regius Professor of Medicine. Total fee for this degree, £13.

*Master of Surgery.*—The candidate must be a Bachelor in Surgery of three years' standing, and must then pass an examination in clinical surgery, operative surgery, surgical pathology, surgery, and surgical anatomy (on the dead subject). Fee for degree, £11.

*Master in Obstetric Science.*—The candidate must have passed the M.B. and B.Ch. examinations, and have completed, in addition to the courses for M.B., B.Ch., a course of obstetric medicine and surgery. He is then required to pass an examination in the following subjects :—Practice of midwifery, gynaecology, anatomy of female pelvis and elementary embryology, and clinical gynaecology. Fee for this degree, £5.

*Diplomatic in Medicine, Surgery, and Midwifery.*—Candidates for the diplomas in Medicine, Surgery, or Obstetric Science must be matriculated in Medicine, and must have completed two years in Arts and five years in

**Medical studies.** The course and examination is the same as for the degrees, except that the lectures and examinations in botany and zoology need not have been taken out or passed, and that the candidate need not have obtained an Arts degree. Fee for the diplomas in medicine, surgery, and midwifery, £21. A diplomate, on completing his course in Arts and proceeding to the degree of B.A., may become a Bachelor by attending the lectures on botany and zoology, passing the previous medical examination in those subjects, and paying the degree fees.

**Diploma in Public Health.**—The candidate must be an M.D. of Dublin, Oxford, or Cambridge, must have completed, subsequent to registration, six months' practical instruction in a laboratory, and also have studied practically outdoor sanitary work for six months, under an approved Officer of Health (*v.* also page 286.).

#### THE ROYAL UNIVERSITY OF IRELAND.

The Royal University of Ireland is purely an examining body. Its degrees are granted on one year's acts, *i.e.*, the matriculation examination of this University (none other will suffice) and a "first University examination" at the termination of the first year. The cost of the M.B. and M.Ch. of the University, with all the necessary curriculum, is about £125. Some of the Arts examinations are conducted, not only in Dublin, but at certain local centres.

The University confers the following medical degrees:—

M.B., B.Ch., B.A.O., and the higher degrees of M.D., M.Ch., and M.A.O. It also confers a diploma in sanitary science and a diploma in mental diseases.

All degrees are open to persons of either sex.

The University examinations are held in the spring, beginning about May 1st, and in the autumn, beginning about October 1st.

All candidates for any degree must pass the matriculation examination and the first University examination.

The course for the degree of M.B., B.Ch., B.A.O., extends over five years.

Students will be admitted to the first University examination after one year from matriculation. Fee, £1.

The medical course consists of three previous examinations, one at the end of each year, and one degree examination at the end of the fifth year. Fee for each previous examination, £1; for the degree examination, £2; for the diploma, £10.

In addition, the following degrees are granted:—**Diploma in Sanitary Science.**—Conferred only on graduates in medicine of the University of at least twelve months' standing. Fee, £2. **Subjects.**—Climatology, chemistry, geology, physics, vital statistics, hygiene, sanitary law.

**The M.D. Degree.**—Conferred only on graduates in medicine of the University of three years' standing. They must at the same time produce a certificate of having been, for at least two academical years, engaged in hospital or private, medical, surgical, or obstetrical practice, or in the military or naval medical service. Fee, £5. The examination comprises medical diseases and the theory and practice of medicine, including pathology. Every candidate will be examined at the bedside, and required to diagnose at least three medical cases, and prescribe treatment, and to write detailed reports on at least two cases to be selected by the examiners and to discuss the questions arising therefrom.

**The M.Ch. Degree.**—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. degree. Fee, £5.

The examination comprises surgery, both theoretical and operative; surgical anatomy; ophthalmology and otology.

**The Mastership of Obstetrics.**—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. and M.Ch. degrees. Fee, £5.

The examination comprises midwifery and diseases of women and children.

**Prizes, &c.**—First examination in Medicine. Two first-class exhibitions of £20 each, and two second of £10 each.

**Second Examination in Medicine.**—Two first-class of £25, and two second-class of £15, and the Dr Henry Hutchinson, Stewart Medical Scholarships, value £10.

The Henry Hutchinson, Stewart Medical Scholarships in psychological medicine, diseases of the nervous system, and anatomy, physiology and pathology of brain, cord, and nerves. Competition among medical graduates of not more than two years' standing. Fee £2.

**Third Examination in Medicine.**—Two first-class exhibitions of £30 each, and two second of £20 each.

**Medical Degrees Examination.**—Two first-class exhibitions of £40 each, and two second of £25 each. One travelling medical scholarship of £100. One medical studentship of £200 per annum, tenable for two years.

#### ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

The examinations held conjointly by the two Colleges are the inlet of most Irish students to the profession, especially of those educated in Dublin. The course, as in other bodies, extends over five years, with examinations at the end of the first, second, third, and final years. These examinations are conducted by examiners chosen by each of the colleges for the subjects appropriate to them. The curriculum has recently been revised, and made of a more practical nature. In common with the English Colleges, the subjects of the First Professional examination may be studied either at a medical school or at an institution other than a medical school recognised by the Colleges, after due inspection, for instruction in these subjects. We recommend students to apply for the official programme to the Secretary of the Committee of Management, Royal College of Physicians, or to the Registrar of either College. In the case of the Preliminary Examination seven clear days' notice must be given to the Secretary; fourteen days' notice are required from candidates for the Professional examination.

The total of the examination fees, spread over the four examinations, is £42, while the school and hospital fees, if taken in Dublin, amount to £124 19s., making altogether £166 19s., exclusive of re-examination fees, which have to be paid in case the candidate fails to pass his examination.

The conjoint Colleges also confer a diploma in Public Health, of which information will be found on page 286.

#### ROYAL COLLEGE OF PHYSICIANS.

This College issues a licence in Medicine and a licence in Midwifery to registered medical practitioners.

The subjects of examination for the former qualification are:—Practice of medicine, clinical medicine, pathology, medical jurisprudence, midwifery, hygiene and therapeutics.

The candidate for the licence in Midwifery must produce certificates of having attended a course of lectures on midwifery, and of having attended practical midwifery and diseases of women for six months, at a lying-in hospital or maternity recognised by the College; or, where such hospital attendance cannot have been obtained during any period of the candidate's course of study, of having been engaged in practical midwifery under the supervision of a registered practitioner holding a public medical appointment, the certificate in either case to state that at least twenty labour cases have been actually attended. A registered medical practitioner of five years' standing is exempted from the examination by printed questions.

**Fees.**—Fee for the licence to practise medicine, £15 15s. Fee for examination for the licence to practise midwifery, £3 3s.

**Membership.**—The Examinations for Membership are held in January, April, July, and October.

#### ROYAL COLLEGE OF SURGEONS.

This College grants a licence in Surgery to registered medical practitioners. Candidates who hold registrable surgical diplomas, including the licence of the Apothe-

caries' Society of London, granted since October, 1886, are admitted to examination without further evidence of study, but candidates who hold medical qualifications only, including the L.S.A. granted before October, 1886, will be required to produce certificates of two courses of lectures in anatomy and dissections, one course of practical histology, one course of lectures in surgery, and one course of operative surgery.

Candidates are examined in surgery, clinical and operative; surgical appliances; and ophthalmic surgery. The fee is £26 5s. The fee for a special examination is £31 10s.

A diploma in Midwifery is also granted after examination to registered medical practitioners. Candidates must produce evidence of (a) attendance on a course of lectures on midwifery and diseases of women and children in a recognised school; (b) attendance on six months' practice at a recognised lying-in hospital or recognised dispensary for lying-in women and children; and (c) of having conducted at least thirty labour cases. The fee for the examination is £15 15s.

*Fellowship.*—Candidates for the Fellowship of the College must enter their names with the Registrar at least a month before the date of examination, in order that the Council may decide whether to approve of the application. Examinations are held the third Mondays in February, May, and November. If the application is approved, the candidate will be admitted to the next sessional examination or to a special examination (except during the months of August and September) if granted by the Council. Candidates are divided into two grades:—

Grade 1.—Licentiates or graduates in surgery of less than ten years' standing.

Grade 2.—Licentiates or graduates in surgery of more than ten years' standing.

Candidates in Grade 1 must pass two examinations—Primary (in anatomy and physiology) and Final (in surgery). Candidates in Grade 2 need pass but one examination in surgery, surgical anatomy, and surgical pathology.

*Fees.*—Grade 1.—For Licentiates of College; Primary examination, £15 15s.; Final examination, £10 10s. Licentiates in Surgery of other licensing bodies: Primary examination, £26 5s.; Final examination, £15 15s. Students of the College: Primary examination, £5 5s.; Final examination, £21. Students of other licensing bodies: Primary examination, £10 10s.; Final examination, £31 10s.

Grade 2.—Licentiates of the College, £26 5s.; Licentiates in Surgery of other licensing bodies, £42.

#### APOTHECARIES' HALL OF IRELAND (L.A.H.).

This body is authorised to grant a complete qualification in medicine, surgery, and midwifery, recognised and registrable under the Medical Act of 1886, and entitling the holder to occupy medical appointments in all the public services. It also confers the legal right to dispense medicines. The examinations are held on the third Monday in January, April, July, and October, and the requirements in respect of studies are approximately the same as those of the Conjoint Examinations of the Royal Colleges of Physicians and Surgeons in Ireland. The examination fees payable for the qualifications of L.A.H. are as follows:—First professional, £5 5s.; second, £5 5s.; third, £5 5s.; Final examination, £6 6s.

The fees for re-examination are £1 1s. for each subject, excepting in the subjects of chemistry, medicine, surgery, and ophthalmology, the fees for which are £2 2s.

The fee for final alone is £15 15s., when the other examinations have been taken elsewhere. Candidates may be admitted to a special examination under special circumstances, at an extra fee of ten guineas.

Each candidate must produce evidence of having before entering on medical studies passed a preliminary examination in general education recognised by the General Medical Council, and of having been registered by that Council as a student in medicine. Certificates of medical study will not be recognised if the commencement of the course to which the certificate refers

dates more than fifteen days prior to such registration. This registration is not undertaken by the Hall, but the student must apply to the Registrar of the General Medical Council that he may be so entered. The details of the course of education required and syllabus of the examinations will be supplied an application to the Registrar at 40 Mary Street, Dublin.

Candidates already on the "Register" will receive the diploma of the Hall on passing an examination in pharmacy and paying a fee of ten guineas. If medicine or surgery should be required two guineas extra will be charged. The candidate will be exempt from each of the above subjects, which are covered by his previous qualification or qualifications.

#### LICENCE IN DENTAL SURGERY.

THERE is probably no speciality in surgery which gives as great a number of its practitioners a living and the prospect of an income as dentistry. A young man who has got his diploma and knows something of his business, and is willing to attend to it, seldom fails to get a substantial foothold in Ireland in a few years. The University of Dublin grants both a Degree and a Licence in dental surgery. To obtain the former, candidates must have taken a degree in arts; the licence is obtainable by all duly qualified persons who have passed the Public Entrance Examination of Trinity College, Dublin. The Royal College of Surgeons in Ireland grants a Licence in Dentistry.

*Course of Study for the Licence in Dentistry.*—Candidates are required to pass three examinations, viz.:—Preliminary (in General Education), Primary Dental, and Final Dental.

All information concerning this licence may be obtained from the Registrar of the College. The Primary Dental Examinations commence on the second Monday in the months of February, May, and November. The subjects of examinations include physics, chemistry (including metallurgy), anatomy, physiology and histology, and surgery. The fees for the primary Dental Examination amount to £10 10s.; and for re-examination, if rejected, £5 5s. The Final Dental Examinations commence on the Thursdays immediately following the Primary Dental Examinations. Candidates are examined in dental surgery, theoretical (including dental pathology), clinical, and operative; and in dental mechanics, theoretical, clinical, and practical (including the metallurgy of the workshop). Candidates must pass in all the subjects at the same time.

The fees for the Final Dental Examination in the case of candidates holding L.R.C.S.I., or students who have passed Primary Dental or Third Professional Examination of the College, £10 10s.; re-examination, £5 5s. The fees for Final Examination of all other candidates, £26 5s., and for re-examination, £10 10s. The extra fee for Special Examination, £5 5s. A rejected candidate will not be again admitted to examination until after a period of three months.

#### THE DIPLOMA IN PUBLIC HEALTH.

THIS diploma is granted by Dublin University, the Royal University, and the conjoint Royal Colleges. Every candidate must be a registered medical practitioner. The examination is in:—(1) Chemistry (including chemical physics). (2) Engineering and architecture. (3) Sanitary law and vital statistics. (4) Hygiene. (5) Bacteriology. (6) Meteorology. The General Medical Council recommend that all candidates shall have studied in a special bacteriological laboratory, also for six months as pupil of a working medical officer of health, described, for Ireland, as "the medical officer of health of a county or of one or more sanitary districts having a population of not less than 30,000; or a medical officer of health who is a teacher in Public Health of a recognised medical school."

In addition to taking the prescribed course a candidate for the D.P.H. of the University of Dublin must be a Doctor in Medicine or a graduate in Medicine, Surgery, and Midwifery of Dublin, Oxford, or Cambridge, and his name must have been on the "Medical Register" for at least twelve months before the examination. The

Royal University only confers its diploma on its own graduates.

#### THE DIPLOMA IN PSYCHOLOGICAL MEDICINE.

The Royal University of Ireland grants a diploma for proficiency in the treatment of mental diseases under the following conditions:—

The diploma is conferred only on graduates in medicine of the University. Candidates must give notice, in writing, to the secretaries of their intention to present themselves, and must pay the prescribed fee of £2 at least one month previous to the examination. Candidates who satisfy the examiners will be required to pay a further fee of £3 before the diploma is conferred. The subjects for this examination are those required by the Hutchinson Stewart Scholarship for proficiency in the treatment of mental diseases.

#### THE IRISH MEDICAL SCHOOLS.

The Irish Medical Schools are as follows:—

**THE SCHOOL OF PHYSIC OF DUBLIN UNIVERSITY.**—This school is formed by an amalgamation of the School of Trinity College and of the College of Physicians.

Every student of the school must be matriculated by the Senior Lecturer, for which a fee of 5s. is payable, but he need not attend any of the Arts course unless he desires to obtain a University licence or degree in medicine, surgery, and midwifery. No student is permitted to matriculate unless he has passed the entrance examinations of the University, of the Royal University, of the College of Surgeons, or some other examination recognised by the General Medical Council.

Two medical scholarships are given annually at the School of Physic, value £20 per annum, tenable for two years, the examinations for which are held each year in June; one scholarship is given in anatomy and institutes of medicine; the other in zoology, chemistry, botany, and experimental physics.

A prize of £100 is awarded by the Board to the successful candidate at a special examination in alternate years in medicine or in surgery, provided that the merit be deemed sufficient. The successful candidate is required to spend three months in the study of medicine or surgery, as the case may be, in Berlin, Paris, or Vienna. Before he can obtain the first instalment of £50 he must satisfy the Senior Lecturer that he possesses sufficient knowledge of a Continental language to derive full benefit from the prize. The examination is held in June, and is open to students who have passed the Final Examination in Medicine or in Surgery, as the case may be, within two years of the examination.

In order to obtain the second sum of £50 the prizeman must have furnished to the Regius Professor his formal report on the hospitals attended by him within two years from the time of obtaining the prize.

Class prizes are given at the end of the session of between £5 and £10 in value.

The John Mallet Purser Medal, founded by Prof. Purser's past pupils, is awarded annually to the student who, at the ordinary June "Half M.B." Examination in Anatomy and Institutes of Medicine, shall obtain highest marks in Physiology and Histology, provided that he passes the examination in full.

**Fitz-Patrick Scholarship.**—This scholarship consists of the interest on £1,000. It will be awarded annually to the student who obtains the highest aggregate marks at the five sections of the Final Examinations, provided that he has completed his medical course in the prescribed period of five years.

**THE ROYAL COLLEGE OF SURGEONS IN IRELAND. SCHOOLS OF SURGERY.**—These schools are attached by Charter to the Royal College of Surgeons, and have existed as a department of the College for nearly a century. They are carried on within the College buildings, and are specially subject to the supervision and control of the Council, who are empowered to appoint and remove the professors, and to regulate the methods of teaching pursued. The buildings have been reconstructed, the capacity of the dissecting room nearly trebled, and special pathological, bacteriological, public health, chemical, and pharmaceutical laboratories fitted with the most approved appliances, in order that students may have the advantage of the

most modern methods of instruction. A refreshment room is now open, where students can have luncheon. There are special rooms set apart for lady students. The entire building is heated by hot-water pipes, and lighted throughout by the electric light.

All the lectures and courses of practical instruction may be attended by medical students who are otherwise unconnected with the College.

The diplomas of the College are open to students of either sex. Separate rooms have been provided, and careful provision made for the instruction and comfort of women students.

**Prizes.**—The Barker Prize, £21; the Carmichael Scholarship, £15; the Mayne Scholarship, £15. The Gold and Silver Medals in Surgery and the Stoney Memorial Gold Medal in Anatomy.

Class Prizes of £2 and £1, accompanied by medals if sufficient merit is shown, will also be given in each subject. Prospectus and Student's Guide can be obtained on written application to the Registrar, Royal College of Surgeons, Dublin.

**THE CATHOLIC UNIVERSITY SCHOOL** is situated in Cecilia Street, Dame Street. It prepares students for all medical examinations, particularly those of the Irish Colleges of Physicians and Surgeons, and the Royal University of Ireland. The school has recently been rebuilt and refitted, its working space having thereby been nearly doubled, and several new laboratories, including those for the study of bacteriology and public health, have been added. The institution has also been recently chartered, under the Educational Endowment (Ireland) Act, and it is now controlled by a Board of Governors. The total fees for school and hospital courses is £160, payable as the courses are taken out.

The following Exhibitions are awarded annually:—Two first year's, value £12 10s. each; two second year's, value £10 each; one third year's Royal Exhibition of £12 10s.; one final Conjoint Colleges' Exhibition of £12 10s.; two large gold medals, besides several other class medals.

A Guide for Medical Students, which gives all the information required by parents, and by students who desire to join the medical profession, may be obtained free on application to the Registrar.

#### THE QUEEN'S COLLEGES—BELFAST, CORK, AND GALWAY.

These three important academic institutions were the special schools of the Queen's University. They have ceased to have any direct relation to a central examining body, but educate students for all colleges and degrees, and are maintained, as hitherto, by a handsome Government grant. The same curriculum as that formerly adopted is continued, and the various exhibitions and scholarships are still available. Each college has the disposal of about £1,500 per annum in scholarships and prizes. The curriculum is generally well adapted for preparation for the Royal University examination. The colleges are well adapted for high-class technical education, having lecture rooms provided with every appliance necessary in the modern training of a medical student. The colleges are completely equipped with students' reading rooms and lending libraries and refreshment rooms, and with all adjuncts to collegiate life, such as literary societies and athletic organisations. The expense of living in the collegiate towns is quite moderate. The course of lectures in the winter session must be diligently attended, no student obtaining a certificate who has not put in three-fourths of a course. The scholarship examinations are held in October.

#### QUEEN'S COLLEGE, BELFAST.

The total cost of the medical curriculum of the Royal University of Ireland, including examination fees and perpetual fee for the Royal Hospital, but not including fees for the special hospitals, is about £95. If the Conjoint Examination of the Royal Colleges is taken the expense is almost the same.

Clinical instruction is given at the Royal Victoria Hospital. The Maternity Hospital, the Ulster Hospital for Women and Children, the Hospital for Sick Children, the Ophthalmic Hospital, the Ulster Eye, Ear, and

Throat Hospital, and the District Lunatic Asylum are also open to students.

*Prizes.*—(1) Ten medical scholarships each year, value £20 each; (2) two Dunville studentships (one each alternate year), value £150 each; (3) one Andrews studentship each alternate year, value £140; (4) numerous sessional prizes.

During the summer session special classes are formed in bacteriology and clinical pathology, and during the winter facilities are afforded to medical men to work at these subjects in the pathological laboratories. From time to time lectures and demonstrations are given in the anatomical department on the Advanced Anatomy of the Nervous System, or some other department of applied anatomy.

A pamphlet containing full information can be had on application to the Registrar, Queen's College, Belfast.

#### QUEEN'S COLLEGE, CORK.

The arrangements in the Faculty of Medicine are made chiefly with reference to the requirements of the Royal University of Ireland, but students proceeding for the examinations of the Conjoint Boards of England, Scotland, or Ireland, the Society of Apothecaries of London, or the Apothecaries Hall of Ireland, can arrange the course of lectures which they attend, and the order in which they attend them, to meet the requirements of those bodies. Certificates of attendance in the college are also accepted by the University of Cambridge. The total fees for the college lectures and Hospital attendances required by the Royal University of Ireland is about £85.

Clinical instruction is given at the North and South Infirmaries. Students can also attend the Mercy Hospital, the Cork Union Hospital, the County and City of Cork Lying-in Hospital, the Maternity, the Hospital for Diseases of Women and Children, the Fever Hospital, the Ophthalmic and Aural Hospital, and the Eglinton Lunatic Asylum. The winter session commences on October 27th, and ends at the end of April. The courses of the summer session are delivered in the months of April, May, and June.

*Scholarships and Prizes.*—Eight medical scholarships, two in each of the first four years, of the value of £25 each, and in the fifth year the Blaney Scholarship of the value of about £32, and a Senior Exhibition, value £30. Three Exhibitions, one in practical medicine, one in practical surgery, and one in practical midwifery, each of the value of £15. Book prizes at the sessional examinations.

Further information can be obtained in the College Regulations, or on application to the Registrar, Queen's College, Cork.

#### QUEEN'S COLLEGE, GALWAY.

Clinical teaching is carried on in the Galway Hospital, established as a Public General Hospital (in the place of the County Galway Infirmary) by Act of Parliament (1892). The Galway Fever Hospital is also open to students. The medical lectures are recognised by the Royal University of Ireland and the various Licensing Bodies in the United Kingdom.

*Prizes.*—There are eight Junior Scholarships in Medicine of the annual value of £25 each. Two are tenable by matriculated students of the first, second, third, and fourth years. The Council has power to award exhibitions for distinguished answering. Sessional prizes are offered in each subject. A Senior Scholarship in Anatomy, value £40, the holder of which is usually appointed Demonstrator, is offered annually for competition, tenable for one year by a student who shall have attended the Medical School of the College for at least two sessions, and shall have obtained a Degree in Arts or Medicine, or a Diploma in Medicine, from a Licensing Body. Scholarship examinations are held at the commencement, and those for Sessional Prizes at the close, of each session.

#### THE PHARMACEUTICAL SOCIETY OF IRELAND.

The Pharmaceutical Society of Ireland issue two qualifications and a certificate. The qualification of Registered Druggist; the qualification of Pharmaceutical Chemist; and the certificate of competency as Assistant to a Pharmaceutical Chemist.

*Registered Druggist.*—This qualification entitles the holder to keep open shop for the selling, retailing, and mixing of poisons. In order to obtain it, a person must now have served an apprenticeship or assistantship of four years to an apothecary, pharmaceutical chemist, or to a person who was, or would have been entitled to become, a registered chemist and druggist or a registered druggist, and be 21 years of age. He shall be examined with respect to his knowledge of English orthography and composition, arithmetic, and the weights and measures of the British Pharmacopœia, the appearance and properties of the various drugs and chemicals in general use, and as to the provisions of the Poisons Act. The fee is four guineas.

Examinations in Dublin (also in Belfast and Cork or other place if 12 candidates offer) on the second Tuesday of January, April, July, and October.

*Pharmaceutical Chemist.*—The qualification of a pharmaceutical chemist in Ireland confers greater privileges than is the case in England.

The subjects of examination are divided between the "Preliminary" and the "Licence."

The Preliminary examination is held on the first Thursday and following day of January, April, July, and October.

The fee is £2 2s. for the first attempt, and 10s. 6d. for each subsequent examination. Further particulars with reference to the subjects for examination may be obtained from the Registrar. The British Society's examination is accepted in lieu of this, as well as those recognised by the General Medical Council as a preliminary to medical studies.

*Pharmaceutical Licence Examination.*—This examination confers the title of Pharmaceutical Chemist and the right to compound medical prescriptions. Candidates must be 21 years of age, and must have passed the Preliminary at least a year previously. They must, unless having passed the Preliminary previous to 1884, produce certificates of having served four years as assistant or apprentice to an apothecary or pharmaceutical chemist or four years to a druggist, two years to an apothecary or pharmaceutical chemist, also a certificate of having attended a course of practical chemistry of not less than three months' duration, and of having actually worked at the bench for 100 hours during the said course at a recognised school; and also a course of botany and materia medica. The fee for examination is five guineas, and for re-examination a guinea and a half. Examinations are held in Dublin on the second Wednesday and following day of January, April, July, and October.

*Assistant to a Pharmaceutical Chemist.*—The examination for the certificate of competency as an assistant may be described, in brief, as the same as that for the Licence, minus the examination in chemistry and botany, with the fee reduced to one guinea (half a guinea on the second and subsequent attempts). The Preliminary examination must be passed as for the Licence, and the usual 14 days' notice must be given. Candidates must have been engaged in practical pharmacy for four years.

Examinations are held on the second Mondays of February, May, August, and November, or on such days as the Council may direct.

#### DEPARTMENT OF AGRICULTURE AND TECHNICAL INSTRUCTION FOR IRELAND.

##### ROYAL COLLEGE OF SCIENCE FOR IRELAND.

SESSION 1904-1905.

This College, situate in Stephens Green, Dublin, supplies a complete course of instruction in science applicable to the industrial arts, especially those which may be cast broadly under the heads of agriculture, chemical manufactures, engineering, physics, and natural science. A diploma of Associate of the College is granted at the end of the three years' course. Non-associate students may join for any course required. There are several entrance scholarships, (a) in agriculture, (b) in science and technology, tenable for three years, of the value of £50 each yearly, with free tuition. There are four Royal scholarships of the value of £50 each yearly, with free education, tenable



for two years. Two are competed for by the associate students at the end of each session. The chemical, physical, zoological and botanical, geological and mineralogical laboratories and drawing schools are open daily for practical instruction. The Session commences on Tuesday, October 4th.

The courses of chemistry, physics, botany, geology, and mineralogy and zoology are recognised by the Royal University of Ireland, and certificates of attendance are granted to medical and other students attending these courses, as also the courses of the chemical, physical, zoological, botanical, and geological laboratories.

#### THE DUBLIN HOSPITALS.

THE clinical hospitals in Dublin are ten in number, exclusive of three lying-in hospitals. There are also two children's hospitals, an orthopædic hospital, a fever hospital, an ophthalmic hospital with two centres, a dental hospital, and other special institutions. Some of the clinical hospitals, though they have no actual or official connection with any school, are in close affinity with certain teaching bodies; while others, again, are without any special connection with any school. While, however, such affiliation of a school or hospital may exist, it should be remembered that the Dublin schools and hospitals are open to all comers, and the student is competent to attend any hospital or any school he wishes, and to change his place of instruction from year to year as he may see fit.

The Irish Licensing Bodies require attendance on hospitals for twenty-seven months, *i.e.*, three winter sessions of six months and three summers of three months, with the five years of study. The fee at all general hospitals is £8 8s. in winter, and for the summer £6 6s., or £12 12s. for the entire session of nine months if taken together.

#### GENERAL HOSPITALS.

RICHMOND, WHITWORTH, AND HARDWICKE HOSPITALS.—The accommodation at these hospitals is as follows:—Hardwicke Hospital, 120 beds; Whitworth Hospital, 82 beds; Richmond Hospital, 110 beds—total, 312 beds. These hospitals are visited each morning at nine o'clock by the physicians and surgeons, and, in addition to the usual bedside instruction, clinical lectures are delivered on the most important cases. Instruction is also given on various special branches of medicine and surgery. The Truss Establishment, for the distribution of trusses to the ruptured poor of Ireland, is connected with these hospitals. There are very large ophthalmic, aural, throat, and gynecological dispensaries, and instruction in these important subjects is given. Six resident clinical clerks are appointed each quarter, and provided with furnished apartments, fuel, &c. The appointments are open not only to advanced students, as formerly, but also to those who are qualified in medicine and surgery. A house surgeon for the Richmond Hospital and a house physician for the Whitworth and Hardwicke Hospitals are elected annually, and receive a salary. The Richmond Lunatic Asylum, containing 1,600 beds, adjoin these hospitals.

MEATH HOSPITAL AND CO. DUBLIN INFIRMARY.—This hospital was founded in 1753, and now contains 160 beds available for clinical teaching. A new building for the isolated treatment of fevers, containing 40 beds, has recently been added. The certificates of this hospital are recognised by all the Universities and licensing bodies of the United Kingdom. Medical and surgical resident pupils and clinical clerks and dressers are appointed every six months, and a house surgeon is elected annually. A prospectus giving the complete arrangements for medical and surgical classes for the coming session may be obtained from the Secretary of the Medical Board, Mr. Conway Dwyer, F.R.C.S., 9 Rutland Square, Dublin.

THE ADELAIDE MEDICAL AND SURGICAL HOSPITALS occupy a central position within a few minutes' walk of the College of Surgeons and Trinity College. From October 1st, the physicians and surgeons visit the wards and give instruction at the bedside at the advertised hours. There is a large detached fever hospital, and also wards for infants and children.

Operations are performed, except in cases of urgency, at 10 a.m. on Tuesday, Thursday, and Saturday. Special hours are devoted to clinical instruction in the diseases peculiar to women, and students are individually instructed in the use of the stethoscope, ophthalmoscope, laryngoscope, and microscope; also special instruction is given on practical pathology and X-ray photography. Three resident pupils are selected half-yearly and two house surgeons annually. Prize examinations, including examinations for the Hudson Scholarship, £30 and a gold medal, and a senior prize of £10 and a silver medal, in addition to surgical and medical prizes, are held at the termination of the session. The large dispensaries afford facilities for the study of eye, ear, throat, and cutaneous diseases, as well as of minor surgery and dentistry. Further particulars from Mr. Heuston, F.R.C.S.I., 15 Stephens Green North.

THE ROYAL CITY OF DUBLIN HOSPITAL.—This hospital has recently been enlarged and improved to a very considerable extent. A special course of instruction is given on ophthalmic and aural disease. There are special wards for the treatment of diseases of the eye, of children, and of women, and practical instruction is given on diseases peculiar to women; there is also a separate building for infectious diseases. Clinical clerks to the physicians and dressers to the surgeons are appointed from the most deserving of the class. A new operation theatre, sterilising room, and anæsthetic room have been constructed in accordance with the most modern surgical requirements. A Röntgen-ray and light treatment of lupus department has recently been added. A resident medical officer is elected annually, and resident medical and surgical pupils are appointed from among the past and present students of the hospital. Operations are performed on Tuesdays, Thursdays, and Saturdays, at 10 a.m. Full particulars can be had on application to Mr. G. Jameson Johnston, M.B., F.R.C.S.I., Hon. Sec. Med. Board.

SIR PATRICK DUN'S HOSPITAL is situated on the south-eastern side of the city, and about half a mile from the University School of Physic. It is officered exclusively by the professors and examiners in that school. Formerly all University students were compelled to attend this hospital, which was purely a medical institution, but some years ago the obligation was removed, and the hospital was opened for surgical cases. It is now free to all students. There is a special wing devoted to fever cases, and regular clinical instruction is given by the members of the medical staff throughout the winter and summer sessions. Special classes for students commencing their hospital studies will be held in these departments during the months of October, November, and December. They will embrace the elements of medicine and surgery, including note-taking. Opportunities are also afforded to students for examining cases of throat, ear, and eye diseases, as well as for performing minor surgical operations and bandaging. In the X-ray Department opportunities are given the members of the hospital class of seeing the various applications of the X-rays to the diagnosis and treatment of injury and disease.

MATER MISERICORDIÆ HOSPITAL.—This hospital, containing 335 beds, is open at all hours for the reception of accidents and urgent cases. Fifty beds are specially reserved for the reception of patients suffering from fever and other contagious diseases. A course of lectures and instruction on fever will be given during the winter and summer sessions. A certificate of attendance upon this course to meet the requirements of the various licensing bodies may be obtained. Opportunities are afforded for the study of the diseases of women in the wards under the care of the obstetric physician, and at the dispensary, held on Tuesdays and Saturdays. Lectures on clinical gynecology will be delivered on Saturdays at 11 a.m. Ophthalmic surgery will be taught in the special wards and dispensary. A special course of instruction in pathology and bacteriology, as applied to medicine, will be given. Connected with the hospital are extensive dispensaries, which afford valuable opportunities for the study of general, medical and surgical diseases, accidents, &c. Leonard

Prizes: One gold and one silver medal will be offered for competition annually in the subject of medicine, and one gold and one silver medal in the subject of surgery. Junior Leonard Prizes: Two prizes of the value of £3 and two prizes of the value of £2 will be offered for competition in medicine and surgery respectively.

**MERCER'S HOSPITAL.**—This hospital, founded in 1707, is situated in the centre of Dublin, in the immediate vicinity of the Schools of Surgery of the Royal College of Surgeons, the Catholic University School of Medicine, and Trinity College. It contains 120 beds for medical and surgical cases, and arrangements have been made with the medical officers of Cork Street Fever Hospital whereby all students of this hospital are entitled to attend the clinical instruction of that institution and become eligible for the posts of resident pupil, &c. There is a large out-patient department, and a special department for diseases peculiar to women. There are also special wards for the treatment and study of children's diseases. During the past few years the hospital has undergone extensive alterations in order to bring it up to modern requirements. A house surgeon is appointed annually. Five resident pupils are appointed, each for six months, and clinical clerks and dressers are appointed monthly from among the most deserving members of the class. The certificates of this hospital are recognised by all the licensing bodies. For further particulars apply to Mr. R. Charles B. Maunsell, M.B., F.R.C.S., 32 Lower Baggot Street, Dublin.

**ST. VINCENT'S HOSPITAL** was established in 1834, it has 160 beds, and in connection with it there is a largely-attended dispensary, a convalescent home, and a nurses' institute. In addition to the ordinary clinical instruction, systematic courses of lectures are given in each department of medicine and surgery, and are illustrated by cases in the hospitals. The resident officers consist of a house surgeon, a house physician, and four resident pupils. Three clinical lectures are delivered daily in the wards, illustrated by selected cases, and beginning at 9 a.m. Two gold medals and other valuable prizes and certificates of merit are awarded at the end of each session. A prospectus can be had from Dr. Tobin, Stephens Green.

**DR. STEEVENS' HOSPITAL**, situated at Kingsbridge, is one of the oldest and largest of the clinical hospitals in Dublin, and contains over 200 beds. Recently, a very fine Nurses' Home has been added to the institution, with accommodation for over seventy nurses. And a new and thoroughly equipped dispensary and out-patient department has been completed and opened to patients. There is accommodation for twelve resident pupils—four medical, six surgical, and two in the special departments, each of whom is supplied with a separate room. All information with regard to these appointments can be had from the Resident Medical Officer at the hospital. Licensing bodies recognise six months' residence as equivalent to a year's ordinary attendance at hospital. The manufactories and railway works in the neighbourhood supply this hospital with large numbers of accidents and other cases, while the special ward for venereal diseases affords exceptional opportunities for the study of this important subject.

**JERVIS STREET HOSPITAL** is the oldest established in Dublin. The new hospital was completed in 1896, since which time it has been open for the reception of patients. In addition to large medical and surgical dispensaries, the out-patient department includes special departments for the treatment of diseases of the skin, eye, ear, and throat, and diseases peculiar to women. Two resident surgeons are appointed annually. Clinical clerks and surgeons' dressers are selected from among the most attentive of the advanced students without the payment of any additional fee. Twelve interns are appointed annually, and are provided with apartments, &c., free of expense. Special certificates are given to resident pupils and dressers who have performed their respective duties to the satisfaction of the physicians and surgeons. Gold and silver medals are given after examinations held at the close of the summer session.

Students of the hospital will get special instruction in the diseases of children and orthopaedic surgery at the Children's Hospital, Temple Street. This will meet the requirements of the R.U.I.

#### SPECIAL HOSPITALS.

The special hospitals of Dublin are the Rotunda, the Coombe, and the National Lying-in-Hospitals, Cork Street Fever Hospital, the Royal Victoria Eye and Ear Hospital (amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Hospital), the Dental Hospital, the Throat Hospital, the Orthopaedic Hospital, the Children's Hospitals in Harcourt Street, and in Temple Street, and the City Hospital for Diseases of the Skin.

**THE ROTUNDA HOSPITAL.**—This institution is the largest, the longest established, and the most famous gynaecological as well as maternity hospital in the British Empire. The work performed by it is about three times greater than that of any other hospital of its kind in Ireland. More than 2,000 patients per annum are admitted to the maternity wards, over 2,700 per annum are attended in the extern maternity department. The patients attending in the out-patient department number over 14,000 per annum. Daily clinical lectures, operations, and practical instruction in midwifery, gynaecology, and cystoscopy are delivered between the hours of 10 and 1 a.m., and a special afternoon class in gynaecology is held by the senior assistant. The new pathological laboratory, under the direction of Dr. Neville, has become an important feature of the hospital. The hospital affords exceptional advantages to qualified men who desire to take out post-graduate courses in practical work. Students can enter at any time for periods of one month or longer. Certificates of attendance are accepted by all the licensing bodies, and the hospital certificate is acknowledged by the Local Government Board as a full legal midwifery qualification. The L.M. certificate is obtained by attendance at the hospital for six months, with the subsequent passing of an examination. A special certificate in gynaecology is given to students whose work meets with the Master's approval. Paid clinical assistants are selected (from among those who have obtained the hospital certificate) by competitive examination for periods of six months. The residents' quarters have recently undergone complete renovation, and afford comfortable accommodation.

**COOMBE LYING-IN HOSPITAL.**—This hospital, which has been rebuilt and considerably enlarged, and contains 70 beds, was founded in 1826 by Mrs. Boyle, and was incorporated by Royal Charter in 1867; it is situated in the centre of a district densely populated by the poorest of the community, and thus affords the amplest opportunities for practice. It receives about 800 labour cases within its walls, while those attended as extern amount to more than 2,000 in number. Moreover, the gynaecological hospital for the reception of cases of the diseases peculiar to women gives admission to nearly 300 patients annually. A new wing for gynaecological cases has been added. The fee for attendance is £8 8s. for six months as extern, and £18 18s. as intern pupil. During that period, the pupil attends on given days and nights in each week, and takes charge in his turn of any case that may be admitted to the labour wards, or may call for his assistance outside. A clinical clerkship is obtainable half-yearly by all pupils who have obtained their midwifery diploma from the hospital, and special certificates are given. Lectures are delivered in the hospital, and clinical instruction is given daily at the bedside. Nurses who take out the usual hospital course of six months receive special instruction in midwifery, and can obtain their diplomas at the termination of the course, on passing the examination.

**\* NATIONAL MATERNITY HOSPITAL.**—This institution, under the mastership of Dr. Barry and Dr. A. Horne, is situated in Holles Street.

**SIR PATRICK DUN'S MATERNITY.**—This is a branch of Sir P. Dun's Hospital, and is under the management of the King's Professor of Midwifery in Dublin University.

The department is at present in process of being re-organised.

**CORK STREET FEVER HOSPITAL** is the only special fever hospital in Dublin. It is supported mainly by an annual Government grant, and capitation grants for patients. Regular clinical instruction is given during the winter and summer session to those who desire a special course in fevers. There are also courses for the Diploma in Public Health. All particulars may be obtained on application to the Medical Superintendent.

**THE NATIONAL CHILDREN'S HOSPITAL** for the treatment of all non-infectious diseases peculiar to children, with which the Pitt Street Children's Hospital, founded in 1821, was amalgamated, is capable of containing 50 beds for the reception of cases of deformity and all other forms of surgical disease. There is a large general dispensary for extern patients held daily from 10 to 11. Operations are performed on Saturday at 12 o'clock. Practitioners and students can attend on application to Sir Lambert H. Ormsby, F.R.C.S.I.

**THE CHILDREN'S HOSPITAL, DUBLIN** (under the care of the Sisters of Charity).—This institution is one of the most progressive and up-to-date children's hospital in the Kingdom, besides being the largest in Ireland. There are 100 beds available for patients; about 1,000 cases are admitted to the wards annually; and about 7,000 or 8,000 seen in the dispensary. During the last year a new operating theatre has been opened. It is fitted and furnished in the best possible fashion for present-day surgery. Special attention is given to orthopædic surgery, and the number of deformities from all parts of Ireland treated and cured in the hospital is rapidly increasing. A special masseuse has been appointed to the hospital to aid in this department. A convalescent home for the institution has recently been acquired at Rahomy; twenty beds are available. While situated in the country, it is within very easy reach of the sea, and during the summer the children are brought daily to the sea-side.

The hospital is recognised for clinical instruction in the diseases of children by the R.U.I. and licensing bodies, which require a certificate of instruction in this important branch of medical education. A nursing home is in connection with the institution, and trained nurses are always available for private cases. Senior students or others requiring a post-graduate course at the hospital should apply for full particulars to H. C. Mooney, hon. sec., or to any member of the staff.

**THE INCORPORATED ORTHOPÆDIC HOSPITAL, IRELAND.**—This hospital was founded in 1876, and contains 70 beds. It is available for every class of deformity available for treatment. Particulars may be obtained from Captain Borthistle, Registrar, at the hospital, or from R. L. Swan, F.R.C.S.I., 32 Stephen's Green.

**THE ROYAL VICTORIA EYE AND EAR HOSPITAL, Adelaide Road, Dublin.**—This hospital, which was opened in March, 1904, is an amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Infirmary. The hospital contains 80 beds. Clinical instruction in diseases of the eye, including the use of the ophthalmoscope and operations, is given daily from 10 till 1. Instruction in aural surgery is also given. Special classes for practical instruction in the use of the ophthalmoscope, &c., and for the demonstration of cases, are formed from time to time.

**THE INCORPORATED DENTAL HOSPITAL, Lincoln Place.**—This handsome hospital, recently erected, is the only special Dental Hospital in Dublin. It is officered by a very strong staff of the leading dental surgeons of Dublin, and has a large *clinielle* and extensive practice among the Dublin poor. The fees are £15 15s. for the first year's study, and £12 12s. for second, and proportionately smaller fees for shorter periods.

**THE CITY HOSPITAL FOR DISEASES OF THE SKIN AND CANCER, Great Brunswick Street.**—The first and only one of its kind in the city was the first in Ireland to instal the Finsen treatment. Senior students are admitted free to the practice of this hospital, which has a large daily out-patient attendance. Classes of instruction will be given at regular intervals during the

winter and summer sessions in the use of the Finsen light, X-rays, high frequency currents and radium, with demonstrations on (1) the production and use of the Röntgen rays, (2) electric currents, direct and alternating, with description of resistances and rectifiers; (3) accumulators, their construction, use, and methods in charging; (4) vacuum tube, choice of tube for particular kinds of work. Fluorescent screen, and how to localize foreign bodies.

#### BELFAST HOSPITALS.

\* **HOSPITAL FOR SICK CHILDREN, Queen Street.**—This institution, erected by voluntary donations, and supported by voluntary contributions, was opened for the reception of patients on April 24th, 1879. The hospital consists of a medical ward with twenty-eight beds, and one of a similar size for surgical cases. It is strictly non-sectarian in its principles, and is open to all denominations. Children from birth to the age of 12 years, and not suffering from contagious disease, are admissible as in-patients. A very large extern is conducted in the out-patient department between the hours of 9 and 10 a.m., where children from birth to 14 years are attended to. The convalescent home, which is situated at Newtownbreda, contains thirteen cots, and its situation and equipment render it an admirable adjunct to the after-treatment of the cases admitted to the hospital. During the winter session systematic courses of lectures and demonstrations in the medical and surgical diseases of infancy and childhood are delivered in the wards on Wednesday and Friday of each week at 9 a.m.

\* **MATER INFIRMORUM HOSPITAL.**—Established 1883. 160 beds.

**THE BELFAST MATERNITY HOSPITAL (INCORPORATED).**—Established 1794. 16 beds.—The practice of the Maternity Hospital, the certificate of which is recognised by the Royal University, &c., &c., is open to students. The fee for the session is £2 2s. Resident nurses are also received for training for a period of six months, and a diploma given which is recognised by public bodies. Conditions for such on application to the Matron. During the year 1903, 326 patients were treated in the hospital, and 304 patients at their own homes. Besides this, 458 patients were dealt with in the extern gynæcological department. Clinical lectures and bedside demonstrations are given by members of the staff during both the winter and summer sessions. Students wishing to attend should apply to Dr. H. D. Osborne, 32 Lonsdale Terrace, Belfast, Hon. Secretary to Medical Staff, on or before November 1st and May 1st.

**OPHTHALMIC INSTITUTION AND EYE AND EAR HOSPITAL, Great Victoria Street, Belfast.**—Established 1844. New hospital erected, 1867. New extern department and operation theatre added, 1902. This hospital is situated on the main road between Queen's College and the Royal Victoria Hospital. It contains about 30 beds for intern patients, and a large extern department. The latter is open on Monday, Wednesday, and Friday at noon for eye cases, and on Monday and Thursday at noon for ear and throat cases. Special courses of instruction are given during the winter and summer sessions, but students can enter at any time, and can always obtain plenty of practice in ophthalmoscopic work. Full particulars may be had from Dr. Cecil Shaw, 18 College Square East, Belfast.

**ROYAL VICTORIA HOSPITAL.**—Established 1791; incorporated by Royal Charter, 1875 and 1898. New hospital opened, September 17, 1903. 300 beds; Convalescent hospital, 24 beds; Children's Hospital, 33 beds; Consumptive Hospital, 10 beds.

**ULSTER EYE, EAR, AND THROAT HOSPITAL.**—Established 1871. New hospital opened 1874. 30 beds.

\* **ULSTER HOSPITAL FOR CHILDREN AND WOMEN, Mountpottinger, Belfast,** is the only hospital in the large part of the city situated on the County Down side of the river. It is placed in a working-class district, and has a great field for its charitable operations. There are in the hospital about twenty-two

beds for children and eight for women. There is an extern department for children open every week-day, except Saturday, from 9 till 10, and for women at 11.30, and a special department for diseases of the eye, ear, and throat on Tuesdays and Fridays from 9 till 10. During the summer and winter sessions, clinical instruction is given to students daily, operations being chiefly performed on Wednesday and Saturday. There is a resident midwife for extern work, and every facility is afforded students for attending their cases in the district.

#### CORK HOSPITALS.

VICTORIA HOSPITAL FOR WOMEN AND CHILDREN.—Established 1874. 70 beds.

\* COUNTY AND CITY OF CORK LYING-IN HOSPITAL.—Established 1798. 17 beds.

\* EYE, EAR, AND THROAT HOSPITAL, Western Road.—Incorporated 1898. 35 beds.

\* FEVER HOSPITAL AND HOUSE OF RECOVERY.—Established 1801. 110 beds.

\* MATERNITY.—Established 1872.

\* MERCY HOSPITAL.—Established 1857. 80 beds.

\* NORTH CHARITABLE INFIRMARY.—Established 1774. 110 beds.

CORK SOUTH INFIRMARY AND COUNTY HOSPITAL.—Founded 1773. The hospital contains 100 beds, available for clinical instruction, 40 medical and 60 surgical. There are also special wards devoted to the treatment of diseases peculiar to women and children, and a large medical and surgical extern department.

Clinical instruction is given daily during the session from 9.30 to 11.30, in both the medical and surgical wards, and clinical lectures are regularly delivered.

The operation and sterilising rooms are thoroughly up to date. The X-ray department is fully equipped with the newest apparatus necessary for such work. Students are regularly instructed in the methods of using the rays by practical demonstration on the cases requiring their use.

The hospital has been largely availed of by students of the Cork School of Medicine.

#### GALWAY HOSPITALS.

\* COUNTY HOSPITAL.—Established 1786. 60 beds.

\* No answer to our request for information received from these hospitals.

#### IRISH PUBLIC SERVICES.

##### THE POOR-LAW MEDICAL SERVICE.

Since the early part of 1899, a vital change has taken place in the Irish Poor-law Medical Service—the service which has, heretofore, absorbed most of the Irish rising medical generation. By the Irish Local Government Act the administration of the system, the appointment and payment and allocation of duties of medical officers was transferred from the old Boards of Guardians, composed in due proportion of members elected by the local voters and members who acted *ex-officio* in virtue of property qualifications, to new boards composed wholly of the elected representatives. This change has placed the sole control of the service in the hands of the elected Guardians, who have, we regret to say, sought to place considerations of economy before everything. The Irish Medical Association, whose work it is to safeguard the interests and improve the condition of the Poor-law medical officer, considers it an imperative duty to point out to young practitioners the following facts:—(1) That the Poor-law Medical Service is one in which there is no promotion. (2) That it is a service where few facilities exist for original research, and still less for further medical culture, especially in the rural districts. (3) That, while medical education has become wider in its requirements, and more costly and difficult to procure, the same or a less rate of payment given to less educated men forty years ago is still offered, and this, too, at a time when the rural prosperity of the country is less, and consequently lucrative private practice more difficult to obtain.

We need go no further than to say that the Irish Poor-law Medical Service is a service to avoid. To all who contemplate entering it we emphatically say, Don't. So important is it that young medical men should recognise what life in the Poor-law Medical

Service means at present that we quote a short extract from a letter written by a member of it:—"We have no pay practically; no holidays. We are always on duty. We have no pension. We have no promotion. Consequently, every day spent in such a service is one day worse, which, I think, makes it fairly rank as the very worst service of any kind in the world, for any other service leads a man to promotion or pension. In addition, the fact of a man being in this service lowers his social status. Everything points to it being a service to be shunned."

Reforms must come finally, but they will only come, as they have come in other services, in consequence of the dearth of candidates. The various branches of the Irish Medical Association through the country have found it necessary to adopt the following resolution:—"That henceforth no medical man shall apply for or accept any dispensary appointment at a smaller remuneration than £200 per annum, or workhouse appointment under £120 per annum, unless both be held conjointly, when the minimum salary shall be £300 per annum." Already the effect of this is being felt, and many dispensary districts are vacant. We desire to point out to the young qualified man the importance of, in all cases, supporting the interests of the profession as a whole on this important question.

There are 159 workhouses and about 813 dispensary medical officers, besides apothecaries. The number of vacancies that occur annually averages 100. The salary in this service used to average about £114, but is rapidly coming down, and when it is taken into consideration that in the vast majority of rural districts it is necessary to keep one or more horses, the average area being from forty to sixty square miles, it is plain that there will not be a large margin left from the public emoluments.

The medical officer is also *ipso facto* the registrar of births, marriages, and deaths, and medical officer of health for the district, under the Public Health Act, passed in 1873 and amended in 1878. The former office, in country districts, yields between £5 and £10 a year, and the emoluments of the latter appointment in very few cases reach £20, averaging about £12. The medical officer is also vaccinator for the locality, and is required to vaccinate everyone who wishes to come. For each patient a fee of 2s. is paid, along with his salary, by the guardians, and the sum total of those fees varies, according to the populousness of the district, from £4 to £100, an average for the provinces being about £10.

*Qualifications.*—The qualifications required by the Local Government Board are a licence in surgery, in medicine, and in midwifery; but registration in the "Medical Register," if effected since the passing of the Medical Act, in 1886, fulfils all requirements. The candidate must also be 23 years of age.

The appointment to both workhouse and dispensary lies with the guardians, who elect by vote. As politics and religious feeling run high in Ireland, these elements enter largely into the election of Poor-law medical officers. Family interests also possess great weight. In some districts an attempt has been made to insist upon the candidate being a member of the United Irish League. We need not—we trust—point out to any member of the medical profession that to endeavour to obtain a post on such a qualification as that of the membership of any political organisation is to commit an act which is unworthy of his profession.

*Duties.*—The duty of the dispensary doctor is twofold. He is to attend his dispensary on a given day or days in the week. Frequently there are two dispensaries in the district, separated from each other by several miles, and he will have, perhaps, to attend two days a week. He has also to visit at any hour of the day or night a sick person for whose relief a visiting ticket has been issued by a member of the committee or the relieving officer, and to continue his attendance as often as may be necessary to the termination of the case. Moreover, he has a great many registry books to keep and a multitude of returns to make, and in many districts he has to make up all the medicines for the poor.

The pressure of these duties is in a great degree dependent on the goodwill of the guardians. If the medical man be a favourite with his masters they will give him very little trouble with "scarlet runners," as the visiting tickets are, from the colour in which they are printed, humorously called, and will be unwilling to trouble him even with cases deserving of personal attendance. If, on the other hand, it is his misfortune to differ from the guardians, his position may become impossible. He may be peremptorily summoned in any weather, at any hour, and to any distance, to a case which he may probably find to be altogether trivial, or to a person whom he may know to be perfectly well able to pay.

**Workhouse Hospitals.**—The number of unions in Ireland in 1899, to each of which is attached a medical officer, who is appointed and controlled by the board of guardians in the same manner as the dispensary surgeon. The salary is usually better than that of the dispensary doctor, and the duties of a more easy and satisfactory description, inasmuch as they are confined to daily attendance at the workhouse hospitals, and no night visits out of doors or long journeys across the country are involved.

**THE IRISH LUNACY SERVICE.**

This service, at present, affords a comfortable livelihood for 22 Resident Medical Superintendents and 32 Assistants. The Superintendents receive salaries and allowances ranging, according to the number of inmates of the asylum, from £500 to £1,000 a year, and the Assistants receive salaries and emoluments averaging about £200 a year. There are also Visiting Physicians receiving about £120 a year, but this class of officer is being allowed to die out, and no new appointments will be made. The Superintendents and Assistants must devote their whole time to their duties.

Heretofore the appointments of Medical Superintendents have been in the patronage of the Lord Lieutenant, but, under the new Local Government Act, they are in the hands of the County Councils, with the proviso that no one shall be appointed who is not a fully registered practitioner with five years' service as Assistant. The Assistant has been, heretofore, appointed by the Board of Governors, and will, in future, be appointed by the Committee of the County Council to which the management of the the asylum is entrusted. In addition to these officers, there are, in certain larger asylums, Clinical Residents, who receive about £50 a year and full allowances. These appointments afford excellent introduction to the higher places in the service.

**OTHER APPOINTMENTS.**

There are, in addition to those which we have mentioned, certain appointments open to medical practitioners in special localities. They are:—

- (1) Attendance on the Royal Irish Constabulary.
- (2) Attendance on the Coastguards.
- (3) Factory Surgeoncies.
- (4) Attendance upon the depôt soldiers who are not otherwise provided for.

The Constabulary are paid for at the rate of 2s. per month for each member of the force on duty in the district, including the wives and children of the men, but not of the officers. This includes the supply of medicines. The appointment to this position rests with the Inspector-General of the Royal Irish Constabulary, who usually acts upon the advice of the local District Inspectors as to the convenience of the men, and, of course, the emoluments depend on the number of Constabulary stations and the number of men in each.

**The Coastguard Service.**—The duty of the Medical Officer is to attend the men when sick and to examine candidates either for admission or for superannuation. The fees vary from 5s. to 2s. 6d. per visit. The appointments rest with the Admiralty, but are usually secured for the local Poor-law Medical Officer. In this case, also, emoluments depend on the number of stations and men.

Factory surgeoncies are in the gift of the Chief Inspector of Factories in Whitehall. There is a set scale of payment by the factory owner to the inspector for this work, but we believe it is not adhered to, and, in some districts, at all events, the emolument is a

matter of arrangement. The amount depends upon the size of the factory, the position being, in Dublin or Belfast, or in other large manufacturing centres, a lucrative one, but in other places scarcely worth taking. The attendance on the military depôts is not worth mentioning.

*The names of the Professors, Lecturers, and Hospital Staffs of the foregoing Schools and Hospitals are not included in this place, being found in the advertisement of each Institution, as indicated below.*

Royal College of Physicians	54	St. Vincent's	...	58
		Richmond, Whitworth and	...	
		Hardwicke	...	52
		Meagh	...	55
		Adelaide	...	60
		Jervis Street	...	60
		<i>Special Hospitals:</i>		
		City Hospital for Diseases of		
		the Skin	...	52
		Rotunda, Lying-in	...	52
		Royal Victoria Eye and Ear	...	55
		National Children's	...	58
		Incorporated Dental	...	54
		<i>General Hospitals:</i>		
Royal City of Dublin	...	61		
Sir Patrick Dun's	...	52		

**Scotland.**

NOTWITHSTANDING the increased competition which the recent vigorous growth of the great English provincial medical schools, added to the unsurpassed attractions of the historic Metropolitan hospitals, with their staffs of renowned teachers, ensures, the Scottish medical schools seem fully to retain their popularity, not only, as is natural, among Scotsmen and their colonial descendants, but among medical students from England, Wales, and Ireland, and, indeed, all parts of our Empire. In fact, if appearances be any guide, it would seem that the number of Oriental students attending classes in Edinburgh is increasing year by year. And undoubtedly the competition of other centres has had the advantage of making Scottish teachers bestir themselves, with the result that the efficiency of the medical schools is now much greater than a decade ago. The Carnegie bequest, which practically ensures free university education to all Scotsmen who are willing to take advantage of it, has considerably increased the number of undergraduates, but it is thought that the increase from this cause has now attained its maximum. The benefit of the second half of the bequest, *i.e.*, the improved equipment of the teaching schools and the encouragement of post-graduate research, are naturally slower in manifesting themselves, but will prove permanent factors in promoting the well-being of the Universities and Scottish education generally. Of the four universities, Edinburgh, of course, occupies the premier position as a medical school, but at Glasgow, Aberdeen, and St. Andrews, an almost equally good, indeed in individual details, better—training can be obtained. Two ordinary qualifications to practise are granted in Scotland—the M.B., Ch.B. of the Universities, and the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow. The standard of examination for the University degree is naturally a good deal higher than that for the triple qualification, and the curriculum wider. Nevertheless, the standard for the latter is being steadily raised, though, on account of the large number of examiners in most subjects it is probably slightly less uniform than that of the universities, where the examinations are conducted by the professors with one or more extra-mural assessors in each subject. Two features of the Scottish system deserve mention—first, as regards the co-ordination of various separate teaching bodies in each centre; second, as regards the conditions under which the students live...

Around each university there has grown up an extra-mural medical school, in which the teachers are hospital physicians, surgeons, and specialists unconnected with the university, but whose classes qualify for graduation. Thus the student has usually ample choice, and can, within certain limits, attend the teacher from whom he thinks he will derive most benefit, while the extra-mural lecturers, being unendowed and constantly recruited by fresh blood, have a permanent incentive to keep their courses up to the mark, since any slackness is at once followed by a diminution in the number of students' fees. In hospital work it is the same, the student having the option of attending a clinical professor and an ordinary physician or surgeon. A very important part of the student's clinical work, too, is done at institutions and under teachers quite unconnected with the universities; this is his dispensary practice, which may be taken at one of several dispensaries situated in the poorer districts of the towns. Until recently, practical training in obstetrics was one of the least satisfactory parts of the teaching in Edinburgh, and many students were in the habit of going to Glasgow to take their maternity work there, where the department is excellently organised and the material ample. Recently, however, steps have been taken which should render this unnecessary, and ought to give Edinburgh students quite sufficient opportunity of acquiring as good a practical acquaintance with this most important subject as they have, and previously had, of obtaining a theoretical knowledge of it. From what has been said it will be seen that university undergraduates and triple qualification men rub shoulders at every turn—in the wards, dispensary, and lecture-room. University students have the privilege of studying under both intra- and extra-mural teachers, while men going up for the triple qualification are limited to the latter. It is not uncommon, therefore, for a man to come up intending to take the licence, and to change his mind and go in for a degree, or *vice versa*, and this can usually be done without much added expense or taking out many fresh classes, provided the change is not made too late in the curriculum.

For the rest, the student lives as he likes and where he likes; the authorities only demand that he shall attend classes with due regularity and diligence, and exhibit sufficient proficiency to pass his examinations. Most men live in lodgings, a few board with private families, and some live in the various halls of residence which have been established. In these last, too, the student is his own master, the halls being managed solely by a committee of the residents for the time being. It is impossible to make any very definite statement as to the relative cost of a medical education in the different schools, as compared with London and Dublin, as so much depends on the extra classes taken out, the mode of living, and so on. The minimum inclusive fees for the Licence are £120, for the M.B. degree about £145; but almost every student finds it practically necessary to attend additional classes. On the whole, the cost of living is highest in Edinburgh, lowest in Aberdeen; in the former, while the rent of lodgings is lower than in London, maintenance, including clothing and provisions, is somewhat more expensive. Incidental expenses, amusements, &c., are, however, considerably less in the Northern capital. In Aberdeen, money goes much further than in the south, and the student ought to keep himself on about two-thirds of the funds required in Edinburgh.

#### THE CARNEGIE TRUST.

Through the munificence of Mr. Andrew Carnegie, LL.D., payment is now made "of the whole or part of

the ordinary class fees exigible by the Universities from students of Scottish birth or extraction, and of sixteen years of age or upwards, or scholars who have given two years' attendance, after the age of fourteen years, at State-aided schools in Scotland, or at such other schools and institutions in Scotland as are under the inspection of the Scottish Education Department."

The Trust provides for the payment of the class fees of the above students proceeding to graduation in medicine or science. Application for payment of class fees under the conditions of the Trust should be made to the Secretary, Mr. W. S. McCormick, Merchants' Hall, Hanover Street, Edinburgh.

Scholarships, Fellowships, and Grants in aid of original research are now awarded annually by the Trust. For particulars, conditions, &c., apply to the Secretary.

#### UNIVERSITY OF EDINBURGH.

Four degrees in medicine are granted: Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The first two must be taken together, the last two may be taken separately.

No one is admitted to the degrees of Bachelor of Medicine and Bachelor of Surgery who has not been engaged in medical and surgical study for five years, after passing a preliminary examination in general knowledge in accordance with the medical ordinances. A degree in Arts or science of a British or other recognised University is held to supersede such preliminary examination. The subjects included in this general examination are English grammar and composition, English history and geography, Latin, arithmetic and the elements of mathematics, and Greek, or French, or German.

The *annus medicus* of each year is held to be constituted by at least two courses of not less than one hundred lectures each, or by one of such courses, and two courses of not less than fifty lectures each, exclusive of the clinical courses, in which lectures are given twice a week during prescribed periods. Two years of the five must be spent at the University, the remaining three years at any University of the United Kingdom, or other Universities or Medical Schools recognised by the University Court.

During the first four years the student must attend elementary botany, elementary zoology, physics, practical chemistry, practical physiology, practical pathology, and medical jurisprudence during courses of not less than 2½ months each; public health, not less than thirty lectures; practical anatomy, during two courses of not less than five months each; chemistry, anatomy, physiology, pathology, surgery; materia medica and therapeutics, medicine, and midwifery and the diseases of women and children during courses of not less than five months each. Eight of these subjects must be taken at a University or college affiliated to a University entitled to grant the degree of M.D. He must attend a course of twenty-five lectures on practical pharmacy in a University or recognised school of medicine, or have dispensed drugs for a period of three months in a hospital or dispensary, or in an establishment recognised by the Pharmaceutical Society. He must attend a nine months' course in clinical medicine and in clinical surgery. During the fifth or final year he must be engaged in clinical study for at least nine months. In all, before graduation he must have attended for at least three years a hospital which accommodates no fewer than 80 patients, and possesses a distinct staff of physicians and surgeons, and he must have acted as clerk in the medical and dresser in the surgical wards of such a hospital, and the practice of a dispensary, or of a physician and surgeon. He must also have had approved opportunities of studying (1) operative surgery, (2) mental diseases at a recognised asylum, (3) at a recognised hospital, post-mortems, fevers, and diseases of the eye, and (4) one of the following: Diseases of children, of the ear, nose and throat, or of the skin, (5) vaccination.

He must personally attend at least twelve cases of labour under the superintendence of a registered



medical practitioner, or six such cases, and, for at least three months, the practice of a midwifery hospital in which practical instruction is regularly given.

Every candidate must deliver on or before the date for lodging certificates for the final examination to the Dean of the Faculty of Medicine:

1. A declaration in his own handwriting that he has completed his twenty-first year, or that he will have done so on or before the day of graduation, and that he will not be, on the day of graduation, under articles of apprenticeship to any surgeon or other master. (This declaration, along with a statement of studies, is appended to the schedule for the Final examination, and must be signed before the schedule is given in.)

2. A statement of his studies, as well in literature and philosophy as in medicine, accompanied with proper certificates.

Each candidate is examined both in writing and *viva voce* :—

1. On zoology, botany, physics, and chemistry.
2. On anatomy, physiology, and materia medica and therapeutics.
3. On pathology.
4. On medicine, surgery, midwifery, forensic medicine, and public health.

The examinations in anatomy, chemistry, physiology, botany, and zoology, materia medica and pathology are conducted, as far as possible, by demonstration of objects placed before the candidates.

Candidates who are ready to submit to an examination in the subjects comprised in the first division, *viz.*, botany, zoology, physics, and chemistry, may be admitted to examination in all or any two of these subjects at any examination held after they have attended a full course in each of the subjects professed.

Candidates who have passed their examination in the subjects in the first division may go up for examination in those of the second division at the end of their third winter session, but may postpone their examination in materia medica and therapeutics until the close of the summer session following.

Candidates who have passed the first and second divisions may be examined in the third division at the end of the fourth winter session.

Candidates who have passed their examinations in the subjects comprised in the first, second, and third divisions may be admitted to examination in the fourth or final division, when they have completed the fifth year of study.

The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of Bachelor of Medicine and Bachelor of Surgery, and who is of the age of twenty-four years, and who produces a certificate of having been engaged, subsequently to his having received the degrees of M.B. and Ch.B., for at least one year in attendance on a hospital, or in scientific work bearing directly on his profession, or in the military or naval medical services, or for two years in practice other than purely surgical. The candidate shall submit to the Faculty of Medicine a thesis certified by him to have been composed by himself, and which shall be approved by the Faculty, on any branch of knowledge comprised in the professional examinations for the degrees of Bachelor of Medicine and Bachelor of Surgery, which he may have made a subject of study after having received those degrees. The candidate will also be examined in clinical medicine and must show practical acquaintance with advanced methods of diagnosis; he may take, at option, gynaecology, mental diseases, or diseases of children for one of his three cases. The degree of M.D. is conferred on holders of the degrees of M.B., C.M. (old regulations), on the submission of a thesis approved by the Medical Faculty, provided that the candidate shall have passed the medical preliminary examination in the subjects of Greek and logic or moral philosophy. Should the candidate elect to do so, he may, however, take the M.D. degree under the new regulations, *i.e.*, substituting an examination in clinical medicine for that in Greek and logic. This course is usually pursued by those who did

not pass in these subjects with the rest of their preliminary examinations.

The regulations for the degree of Ch.M. are very similar, the candidate being examined in surgical anatomy, operations on the dead body, clinical surgery, and some of the special branches.

Candidates settled abroad, who cannot appear personally to receive the degree, may, after satisfying the Senatus to that effect, have the degree conferred on them *in absentia*.

*Fees* :—The fee to be paid for the degrees of Bachelor of Medicine and Bachelor of Surgery is twenty-two guineas, and the proportion of this sum to be paid by a candidate at each division of the examination is registered from time to time in the University Court. The fee for the degree of Doctor of Medicine or of Master of Surgery is ten guineas (old regulations, £5 5s.).

The total expenses of the curriculum, including examination and matriculation fee, is £146.

Bursaries and scholarships open for Session 1904-1905: Among the bursaries and scholarships open during the ensuing year are:—Freeland Barbour Fellowship of £100 in Anatomy, and Physiology, and Pathology. Allan Fellowship of £48 15s. in Clinical Medicine and Surgery. Heriot bursaries, applications to Treasurer, 20 York Place, before September 15th. Mackay Smith scholarship in Chemistry, value £25. Two Mackie bursaries for students in second and third years, whose pecuniary circumstances need assistance. Applications to Dean by October 1st. Four Buchanan bursaries. Two Sibbald bursaries of £30, and a medical scholarship of £40 a year for three years, particulars from Messrs. Mackenzie, Innes, and Logan, W.S., 23 Queen Street, Edinburgh, before September 15th. Two Thomson bursaries of £25 for four years, one conferred at each preliminary examination in October and March. Five Grierson bursaries (natives of Crawford and Leadhills have a preference). Names must be sent in before October 1st. Two John Aitken Carlyle bursaries of £28 for one year for proficiency in class examinations in anatomy and chemistry or physiology. Four Mackenzie bursaries of £20, in practical anatomy. Renton bursary of £20 for one year, for students attending classes of natural physiology, mathematics, chemistry, or political economy, who also can show they are in need of pecuniary aid. Two Crichton bursaries of £50, for four years, one competed for at each preliminary examination. Buchanan scholarship of £40 10s., for proficiency in midwifery and gynaecology, as shown by class work and in the final examination. Other scholarships are:—The James Scott, £42 10s. annually, in midwifery; the Ettles, £31 5s. annually to the most distinguished graduate; two Hope prizes, £30 annually in chemistry; two Crichton, £100 annually, for research in anatomy and physiology. One Vans Dunlop scholarship in preliminary subjects, value £100. Moutat scholarship in practice of physic, about £55. Houldsworth scholarship in Pharmacology, £40. For details of these, as well as a number of other prizes, bursaries, &c., the University Calendar must be consulted.

Graduation in Science: The University of Edinburgh also possesses a Faculty of Science which may confer two degrees, Bachelor of Science (B.Sc.) and Doctor of Science (D.Sc.). These degrees are given in pure science and in applied science. Candidates for the degree of B.Sc. in pure science must attend at least seven courses of instruction in the subjects selected by them during the course of not less than three academical years. Three of these courses must be on subjects prescribed for the first science examination, and four on those for the final examination. Four of these courses must be taken in the University of Edinburgh. The subjects for the first science examination are:—1, Mathematics or biology (first professional in medicine not accepted as equivalent to latter); 2, Natural philosophy; 3, Chemistry. For the second examination they may be selected from among the following: Mathematics, physics, astronomy, chemistry, anatomy, physiology, geology, zoology, and botany. Graduates

as B.Sc. may, after five years, proceed to the degree of D.Sc., undergoing an examination in the subjects chosen, and presenting a thesis founded on original work.

**Graduation in Public Health:** Similar degrees are conferred in Public Health. Candidates must be graduates in medicine of a University recognised by the University Court, and must matriculate for the year in which they proceed for examination. Before proceeding to the first examination they must produce evidence that (1) they have worked at least twenty hours a week during a period of not less than eight months, after taking their medical degree, in a recognised Public Health laboratory. Five of these months must be spent consecutively in the Public Health Laboratory of the University of Edinburgh, and (2) have attended a course of lectures on physics in addition to that qualifying for graduation in medicine, and one, of at least three months' duration, on geology, such as the Senatus may approve of.

Candidates for the second examination of B.Sc. in Public Health are not admitted until at least eighteen months have elapsed after having passed M.B., Ch.B., or sooner than six months after the first examination. They must have attended two separate courses of Public Health, of at least forty lectures each, one dealing with medicine, the other with engineering, each in its relation to public health, in such manner as the Senatus shall determine. They must also have studied practical sanitary work under a Medical Officer of Health for six months, have had three months' clinical instruction in a recognised fever hospital, and three months' instruction in mensuration and drawing.

Full details of the subjects included in the different courses are given in the official programme of the Faculty of Science, which may be obtained from the University (price 2d.).

In a similar manner to that described under degrees in pure science, a B.Sc. may after five years proceed to take the degree of D.Sc. in Public Health.

Fees for Science Degrees: B.Sc., first examination, £3 3s.; B.Sc., second examination, £3 3s.; D.Sc., £10 10s.; total, £16 16s.

**University Hall, Edinburgh.**—In an educational number it is worth while to call attention to the advantages now offered to students coming to Edinburgh to study, in the shape of social residences akin to, though very much less pretentious than, the English University colleges. During the past six years several buildings have been acquired in Edinburgh for this purpose, in which students can live in a self-governing community. In each house there are private studies with or without bedrooms, and common sitting and dining rooms. The charges vary from 7s. 6d. to 22s. 6d. per week. The residents elect a treasurer from among their number who acts as intermediary between them and the housekeeper or servants. It is a satisfactory indication of the comfort of the Hall that several graduates now live in it and are willing to help or coach the undergraduates for moderate fees. To gain admission two references must be produced from past or present residents. These are considered and voted on at a house meeting. In all disputed points Professor Geddes is the referee, while Dr. Ricardo Stephens is the rent treasurer, who will supply any further information required. The Hall is an admirable place for parents to send their sons to. Any unruly member may be expelled by a meeting of the residents similar to that held for elective purposes.

**Medical School for Women.**—The medical teaching of women in Edinburgh is carried on by the Scottish Association for the Medical Education of Women (the Secretary, Minto House, Chambers Street). The classes are conducted by the lecturers of the Medical School of the Royal Colleges, and qualify both for the Edinburgh University degree and for the Licence of the Triple Board. The classes are for women alone. The University of Edinburgh does not recognise certificates presented by female candidates for mixed classes without special cause shown. Women students are eligible for the benefits of the Carnegie Bequest,

#### UNIVERSITY OF GLASGOW.

The University of Glasgow is both a teaching and an examining body, but admits to examination only those candidates whose course conforms to its own regulations. Within certain limits provision is made for accepting instruction given by recognised medical schools and teachers; but eight of the subjects other than clinical must be taken in this or some other recognised University entitled to confer the degree of M.D., and at least two years of the course must be taken in Glasgow University. Under the new regulations, laid down in Ordinance No. 14, Glasgow No. 1, of the Commissioners under the Universities (Scotland) Act, 1889, four degrees, open both to men and to women, are conferred—M.B. and Ch.B. (always conjointly), M.D. and Ch.M. A preliminary examination must be passed in (1) English, (2) Latin, (3) Elementary mathematics, and (4) Greek, French, or German, with possible option to students whose native tongue is not English in the case of the fourth subject, and on passing, students must register in the books of the General Medical Council. By a regulation recently enacted, it is no longer compulsory to pass in all the four preliminary subjects at once, and they may now be passed at two stages. For M.B. and Ch.B. a curriculum of five years is required. A syllabus with full details of the curriculum and of the preliminary examination may be had, post free, on application to the assistant clerk, Matriculation Office.

The fees for M.B. and Ch.B. are £23 2s.; for M.D. £10 10s., and for Ch.M. £10 10s. For hospital attendance there is an initial fee of £10 10s., with a further fee of £3 3s., for each winter session, and £2 2s. for each summer session of clinical instruction. There are three very extensive general hospitals in the city, which afford exceptional opportunities for clinical work, while the Royal and other asylums, the City Fever Hospital, the Maternity Hospital, the Sick Children's Hospital, the Eye Infirmary, &c., give facilities for the study of special branches.

The degrees of B.Sc. and D.Sc. in Public Health are also now conferred. Of late the University has made considerable efforts to extend its laboratory accommodation and equipment, to augment its teaching staff, and to encourage post-graduate and research work. Within the last few years there have been provided new laboratories in the departments of pathology, anatomy (costing £13,000), chemistry, and surgery (costing £9,900); while new laboratories, to cost, with equipment, upwards of £60,000, are now in course of erection for the departments of physiology, materia medica, and medical jurisprudence and public health.

Bursaries and prizes to the annual amount of about £900 are appropriated to medical students, including an Arthur bursary for women, £25 for three years.

Several bursaries open to students in any faculty are not infrequently held by medical students, and Scholarships and Fellowships to the annual amount of £1,600 may be held by medical students who have gone through the Arts course.

**Queen Margaret College for Women.**—Founded in 1883 (by the Glasgow Association for the Higher Education of Women, which was formed in 1877 with the object of bringing University instruction, or its equivalent, within the reach of women), Queen Margaret College in 1890 added to its faculty of Arts a School of Medicine for Women. This was organised entirely on University lines, and with the view of preparing for University degrees; and when, in 1892, in consequence of the Ordinance of the University Commissioners authorising the Scottish Universities to admit women to instruction and graduation, Queen Margaret College became the Women's Department of the University of Glasgow, its classes in medicine taken previously to its incorporation with the University were recognised as preparing for the degree. A full course of study for M.B. and Ch.B. is given by University professors and lecturers, with excellent facilities for hospital and dispensary work in the Royal Infirmary and other hospitals. A Hall of Residence for the students was founded six years ago. Fees for the classes

at Queen Margaret College may be paid by the Carnegie Trustees.

#### UNIVERSITY OF ABERDEEN.

The University of Aberdeen possesses under its charters the amplest privileges claimed or enjoyed by any academical institution. It confers degrees in the five faculties of Arts, Science, Divinity, Law, and Medicine. It also grants diplomas in Public Health, Agriculture, and in Education. It is, moreover, a teaching body equipped with twelve distinct chairs in the various branches of medicine and surgery, besides a Lectureship in Tropical Medicine. The majority of the professors devote their whole time to the work of the chairs. There are fully-equipped laboratories, the accommodation for which has recently undergone considerable extension. The degrees of M.B. and Ch.B. are conferred together; they cannot be obtained separately. The curriculum of study is nearly the same as in the University of Edinburgh; the regulations in the preceding columns will therefore apply here. Two years must be passed at Aberdeen. With regard to fees, each candidate for the degrees of M.B. and Ch.B. must pay a fee of £5 5s. in respect of each of the first three professional examinations, and £7 7s. for the final examination. Total cost, exclusive of the fees for degrees, is about £130. Besides the Royal Infirmary, students have the opportunity of attending several other local institutions where special courses of instruction are given. Perpetual fee for hospital practice is only £6. The professional examinations are held twice in each year, namely, in March and July, directly after the close of the winter and summer sessions.

**BURSARIES.**—Bursaries, Scholarships, and Fellowships to the number of fifty, and of the annual value of over £1,183, may be held by students of medicine. (See "University Calendar.")

**THE DEGREE OF M.D.**—The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of M.B. and C.M. (Old Regulations), is of the age of twenty-four years, and has been engaged subsequently to his having received the degree of M.B. for two years in attendance in a hospital, or in military or naval medical service, or in medical or surgical practice, and has presented a thesis which has been approved of by the Medical Faculty. Candidates for the degree of M.D. (New Regulations) are required to pass an examination in clinical medicine in addition to presenting a thesis. Similar regulations apply to a degree of Ch.M. (Master of Surgery).

A Diploma in Public Health is conferred after examination on graduates in medicine in any University in the United Kingdom. Regulations may be seen in the "Calendar," or obtained on application to the Secretary the Medical Faculty.

**Aberdeen Royal Infirmary.**—This is a well-equipped institution, containing 250 beds, and affords excellent opportunities for clinical study to students at the Aberdeen University. The city, moreover, offers inducement in the way of cheaper living and comparative quiet to that obtained in Edinburgh and Glasgow, and will doubtless be preferred by some on this account.

#### ST. ANDREWS UNIVERSITY.

##### UNITED COLLEGE ST. ANDREWS AND UNIVERSITY COLLEGE, DUNDEE.

This University (session opens October 7th) grants the degrees of M.B., Ch.B., M.D., and Ch.M. The degrees of the University are open to either sex. For the degree of M.B., Ch.B., two of the five years of medical study must be spent in the University of St. Andrews; the remaining three may be spent in any University of the United Kingdom, or in any foreign, Indian, or Colonial University recognised for the purpose by the University Court, or in such medical schools or under such teachers as may be recognised for the purpose by the University Court. The preliminary examination and the professional examinations are of the same character as in the other Scottish Universities. A Diploma in Public Health is also granted by the University of St. Andrews to graduates in medicine of any University in the United Kingdom. Twelve months must elapse between the date of graduating in

medicine and entering for the examinations for the diploma. The course of study required consists of (1) a six months' course of practical chemistry, bacteriology, and the pathology of diseases transmissible from animals to man in a laboratory of the University of St. Andrews; (2) six months' work with a medical officer of health; (3) three months' clinical instruction in infectious diseases. Subjects for first examination:—Chemistry, physics, bacteriology, and meteorology. Second examination:—Sanitation, sanitary law, vital statistics, medicine in relation to public health.

*University College, Dundee*, was affiliated and made to form part of the University of St. Andrews on January 15th, 1897, and the whole medical curriculum may be taken in the College. The United College, St. Andrews, offers classes for the first two years of professional study.

#### BURSARIES AND SCHOLARSHIPS.

**United College, St. Andrews.**—Malcolm bursary £25 a year, tenable for five years). Fourteen T aylour Thomson bursaries, £30 to £20, five tenable for one year, nine for two, open to women only proceeding to graduate in medicine.

**University College, Dundee.**—Eleven entrance bursaries of £15, open to women for arts, science, or medicine, tenable for one year. Four £20 and three £15 second year bursaries for men or women in arts, science, or medicine, tenable for one year. Four £20 and two £15 third year bursaries for men or women in arts, science, or medicine, tenable for one year. Two Educational Trust bursaries of £25, tenable for three years. Applicants must have attended a public or State-aided school in Dundee for at least one year before examination. Bute bursary, annual income from £1,000 (men only).

**Preliminary Examinations.**—The dates of the next two examinations are September 23rd, 1904, and March 24th, 1905. Schedules (obtainable from the Secretary of the University) to be returned filled up, and fees paid by September 10th, 1904, or March 8th, 1905.

**Fees for Degrees.**—Total fees for M.B., Ch.B., are the same as at other Scottish Universities, *i.e.*, 22 guineas (payable in instalments). Fee for the degree of M.D., and also for that of Ch.M., is 10 guineas in each case. For the Diploma of Public Health examinations the fee is £5 5s. for each of the two examinations.

**Class Fees.**—The fee payable in each of the following classes is 4 guineas, *vis.*:—Chemistry, Physics, Zoology, Botany, Physiology, Anatomy, Materia Medica, Pathology, Forensic Medicine, and Public Health, Medicine, Surgery, and Midwifery. The fee for the practical classes in these subjects is 3 guineas each. In Clinical Surgery, Clinical Medicine, Ophthalmology, Diseases of the Throat, Nose, and Ear, and Mental Diseases, the class fees are 2 guineas each. The fee for Public Health Chemistry required for the D.P.H., is £7 7s. A special class in Bacteriology is also held for the D.P.H. for which the fee is 3 guineas.

**Dundee Royal Asylum.**—The appointments include a qualified resident assistant and two resident clinical clerks. Clinical instruction is given.

Further information will be found in the Calendar of the University, published by Messrs. Blackwood and Sons, Edinburgh, or can be had of the Dean of the Medical Faculty, Professor Weymouth Reid, F.R.S.

**Dundee Royal Infirmary.**—The Infirmary contains 300 beds, with a special ward for the treatment of children. Three resident qualified assistants are appointed annually. Clinical clerks and dressers are attached to the physicians and surgeons, and students are appointed to assist in the post-mortem room. Out-patients are seen daily at 9 a.m. The instruction given at the Infirmary is recognised for purposes of graduation by the Scotch Universities, the University of London, the University of Cambridge, the Royal University of Ireland, and by the Royal Colleges of England and Scotland. Hospital Ticket for the Infirmary, £2 2s. each session, or £3 3s. a year. Further information on application to the Medical Superintendent.

#### THE COLLEGES.

The Royal College of Physicians of Edinburgh, the

Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow have made arrangements by which, after a series of examinations, the student may obtain the diploma of the co-operating bodies.

The holders thereof are enabled to register three diplomas under the Medical Acts, *viz.*, Licentiate of the Royal College of Physicians of Edinburgh, Licentiate of the Royal College of Surgeons of Edinburgh, and Licentiate of the Faculty of Physicians and Surgeons of Glasgow. The diplomas are also recognised by the Army, Navy, and other public bodies.

The three co-operating bodies grant their *single* qualifications only to candidates who are already registered as possessing another and opposite qualification in medicine and surgery, as the case may be.

REGULATIONS OF THE CONJOINT BOARD OF THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH AND THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH AND THE FACULTY OF PHYSICIANS AND SURGEONS, GLASGOW.—The candidate must produce certificates of having attended the following separate and distinct course of lectures, the certificate distinguishing the sessions and the schools in which the courses were severally attended. Anatomy, one course, six months. Practical anatomy, twelve months. Chemistry, one course, six months. Practical or analytical chemistry, one course, three months. *Materia medica*, one course, three months. Physiology, one course, six months. Practice of medicine, one course, six months. Clinical medicine, nine months. Principles and practice of surgery, one course, six months. Clinical surgery, nine months. Midwifery and diseases of women and children, one course, three months. Medical jurisprudence, one course, three months. Pathological anatomy, one course, three months. The candidates must also produce the following certificates:—(a) Of having attended not less than six cases of labour under the superintendence of the practitioner who signs the certificates, who must be a registered medical practitioner. (b) Of having attended for three months' instruction in practical pharmacy. The certificate to be signed by the teacher, who must be a member of the Pharmaceutical Society of Great Britain, or the Superintendent of a laboratory of a public hospital or dispensary, or a registered practitioner who dispenses medicine to his patients, or a teacher to a class of practical pharmacy. (c) Of having attended for twenty-four months the medical and surgical practice of a public general hospital, containing on an average at least eighty patients, and possessing distinct staffs of physicians and of surgeons. (d) Of having attended, for six months, the practice of a public dispensary specially recognised by any of the co-operating bodies; of having been engaged for six months as visit-assistant to a registered medical practitioner. (e) Of having been instructed in vaccination.

*First Examination, Fee £5.*—The first examination shall embrace chemistry, comprising the following particulars:—Chemical physics, heat, light, and electricity; the principal non-metallic and metallic elements, and their more common combinations, also the leading alcohols, organic acids, ethers, carbohydrates, and alkaloids; the candidates will also be examined practically in testing; physics and elementary biology. The first examination shall take place not sooner than the end of the first year, including a winter and summer session. Candidates who desire to enter for the first professional examination must apply to the Inspector of Certificates on or before the Friday preceding the day of examination, and must produce certificates of attendance on one course of chemistry, one course of practical chemistry, one course of anatomy, and six months' practical anatomy.

*Second Examination, Fee £5.*—The second examination shall embrace anatomy and physiology, and shall not take place before the termination of the summer session of the second year of study. Candidates must produce to the Inspector certificates of attendance on the prescribed courses of anatomy, practical anatomy, and physiology.

*Third Examination, Fee £5.*—Comprises the subjects of pathology, *materia medica*, and pharmacology and advanced anatomy.

*Final Examination, Fee £15.*—The Final examination shall embrace the principles and practice of medicine (including therapeutics and medical anatomy, clinical medicine); the principles and practice of surgery (including surgical anatomy and surgical pathology); clinical surgery; midwifery and gynaecology, medical jurisprudence and hygiene; and shall not take place before the termination of the full period of study.

Subjects of Preliminary Education: (1) English language, including grammar and composition; (2) Latin, including grammar, translation from specific authors, and translation of easy passage not taken from such authors; (3) elements of mathematics, comprising (a) arithmetic, including vulgar and decimal fractions; (b) algebra, including simple equations; (c) geometry, including the first two books of Euclid; (4) elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, and hydrostatics; (5) one of the following optional subjects:—(a) Greek; (b) French; (c) German; (d) Italian; (e) any other modern language; (f) logic; (g) botany; (h) zoology; (i) elementary chemistry.

Qualification in Public Health: The College of Physicians, in association with the Royal College of Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, confers a certificate of competency in public health. The examinations are held in April and October. Fee, £10 ros.

For the special regulations of the Royal College of Surgeons of Edinburgh, intending candidates should apply to Mr. James Robertson, 48 George Square, Edinburgh; and for those of the Royal College of Physicians, to Dr. R. W. Philip, 45 Charlotte Square, Edinburgh.

The Fellowship of the Royal College of Physicians of Edinburgh is conferred only by election, and the candidate must have been a member of the college for at least three years previously, and have attained the age of twenty-seven years.

The Membership is conferred only on a licentiate of a college of physicians or graduate in medicine of a British or Irish University, provided he shall have attained the age of twenty-four years and shall have passed an examination (1) On the principles and practice of medicine, including therapeutics; (2) on one of the following subjects to be selected by the candidate, *in which a high standard of proficiency is expected*:—(a) one or more departments of medicine specially professed; (b) psychological medicine; (c) pathology; (d) medical jurisprudence; (e) public health; (f) midwifery; (g) gynaecology. The examination is of a searching character extending over three days, the first of which is devoted to the examination of patients, *visu voce* and practical examination on methods of diagnosis—*e.g.*, microscopy of blood, clinical bacteriology, quantitative analysis, &c., and written commentary on a case examined. The second day is taken up by written papers, and the third by practical examination on special subject and orals.

The fee for membership is 35 guineas, for fellowship 38 guineas, with a stamp duty of £25—£101 13s. in all.

The licence, or single qualification in medicine, is conferred on candidates who already possess a recognised qualification in surgery. The examinations for this licence are held on the first Wednesday of each month, save those of September and October, in medicine, *materia medica*, midwifery, and medical jurisprudence. The fee is £15 15s., and intending candidates should communicate with the Secretary of the College at least eight days before the date of examination.

The Fellowship of the Royal College of Surgeons of Edinburgh is conferred (except under certain conditions as to age and professional standing) only on candidates who have passed a special examination, and have previously obtained a diploma from the college, or from either of the Colleges of Surgeons of England or Ireland, or the Faculty of Physicians and Surgeons of Glasgow, or the surgical degrees of the Universities of Great

Britain, and who are twenty-five years of age. The subjects for examination for those who are already Licentiates of the College are on the principles and practice of surgery, clinical and operative surgery, and one optional subject.

Those who are not Licentiates of this College: on principles and practice of surgery, clinical and operative surgery, surgical anatomy, and one optional subject; and in such supplementary subjects as have not, in an adequate manner, been included in the examination for the registrable surgical qualification possessed by such candidates, and which are required in the examination for Licentiates of this College.

The optional subjects shall embrace: (a) Surgery; special branches; (b) advanced anatomy and physiology; (c) surgical pathology and morbid anatomy; (d) midwifery and gynaecological medicine and surgery; (e) medical jurisprudence and hygiene; (f) practice of medicine and therapeutics. The examinations are written, oral, and practical. Three weeks' notice must be given to Mr. James Robertson, from whom full particulars as to certificates required may be obtained. The fee is £30 for those who hold the diploma of Licentiate of the College, and £45 to others (no stamp duty is payable on the diploma). Registered practitioners, aged not less than 40, who have been in practice for not less than ten years, and who have highly distinguished themselves by original investigations, may under special circumstances be elected without examination. Women are not admitted to the Fellowship.

**LICENCE.**—The examination embraces the principles and practice of surgery (including operative surgery and surgical pathology), clinical surgery, and surgical anatomy, and shall not take place before the termination of the full period of study. Fee, £15 15s.

**WOOD BURSARY.**—The examination for the Wood Bursary, of £60 per annum, tenable for three years, will take place on October 21st and 22nd, at the college. The subjects will be found in our advertising columns.

**DENTAL DIPLOMA.**—Every candidate for the dental diploma must have attended the general lectures and courses of instruction required at a University or an established medical or dental school recognised by the College as qualifying for the diploma in surgery. The fee is £10 10s.

**Edinburgh Royal Infirmary.**—Clinical instruction is afforded at this institution, which contains 780 beds in the building, and 10 beds in a convalescent home under the supervision of professors of the University and the ordinary physicians and surgeons of the Infirmary. Special instruction is given on diseases of women, physical diagnosis, diseases of the eye, ear, throat and teeth, and anaesthetics. Separate wards are devoted to venereal diseases, diseases of women, diseases of the eye, also to cases of incidental delirium or insanity, and three wards are specially set apart for clinical instruction to women students. Post-mortem examinations are conducted in the anatomical theatre by the pathologists. The perpetual fee, on one payment, £12; the annual fee, £6 6s.; half-yearly, £4 4s.; quarterly, £2 2s.; monthly, £1 1s. Separate tickets amounting to £12 12s. entitle the student to a perpetual ticket. No fees are payable for any surgical or medical appointment.

The appointments are as follows:—

1. Resident physicians and surgeons are appointed and live in the house free of charge. There is no salary. The appointment is for six months.
2. Non-resident physicians and surgeons (in the special subjects and for out-patient work) are appointed for six months. These appointments may be renewed.
3. Clerks and dressers are appointed by the surgeons and physicians. These are open to all students and junior physicians holding hospital tickets.
4. Assistants in the pathological department are appointed by the pathologists to conduct post-mortem examinations in the anatomical theatre.

### SCHOOL OF MEDICINE OF THE ROYAL COLLEGES, EDINBURGH.

The government of this school, established in 1505, is now vested in a board which is equally representative of the two Royal Colleges and the Lecturers, the school being styled "The School of Medicine of the Royal Colleges, Edinburgh." The present number of lecturers is about sixty, of whom the greater number deliver qualifying courses of instruction of the same duration and scope as those delivered within the University, while a large number of non-qualifying courses on special subjects of interest to medical science, but which are not required for graduation, are delivered both in the winter and summer sessions. The students who attend the classes of the School of Medicine are largely students proceeding to the University degree, as well as those who are intending to take other qualifications, such as the triple qualification of the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow; that of the Royal College of Physicians of London, and the Royal College of Surgeons of England, and the degrees of the different Universities. The number of students attending the school averages 1,300 annually.

The minimum cost of the education in the School of Medicine for the triple qualification of physician and surgeon from the Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, including the fees for the joint examinations, is about £120, which is payable by yearly instalments during the period of study.

The Winter Session opens October 1st.

### GLASGOW EXTRA-MURAL SCHOOL.

**St. Mungo's College and Glasgow Royal Infirmary.**—This college was incorporated in 1889 under its new title, being formerly known as the Glasgow Royal Infirmary School of Medicine. The Medical Faculty occupies buildings erected for the purpose of the medical school in the grounds of the hospital, and the laboratories, museums, and lecture rooms are of the most approved description. The college has been recently equipped with a complete electric light installation, and a powerful electric educational lantern. Attendance on the classes in St. Mungo's College qualifies for the medical degrees of the Universities and the medical and surgical colleges in accordance with their regulations.

The Royal Infirmary, which is at the service of the College for teaching purposes, is one of the largest general hospitals in the kingdom. It has over 600 beds available for clinical instruction, including an ophthalmic department, and it has special wards for diseases peculiar to women, for venereal diseases, erysipelas, burns, and diseases of the throat. At the dispensary special advice and treatment are given in diseases of the eye, ear, teeth, and skin, in addition to the large and varied number of ordinary medical and surgical cases—about 78,000 per annum—which in a great industrial centre daily require attention. Students at the college and hospital get the benefit of dispensary experience free of charge, and no better or wider field for seeing hospital practice and receiving clinical experience can be found than in the Glasgow Royal Infirmary.

**Appointments.**—All appointments are open. There are five physicians' and eight surgeons' assistants, who obtain free board and residence in the hospital and act in the capacity of house physicians and house surgeons. There is also a house surgeon for the ophthalmic department. These appointments are made for six months, and are open to gentlemen who have a legal qualification in medicine and surgery. Clerks and dressers are appointed by the visiting physicians and surgeons. From the large number of cases of acute diseases and accidents of varied character received, these appointments are valuable to students. In the pathological department assistants are also appointed by the pathologist.

**Fees.**—The fees for Lectures, including Hospital attendance necessary for candidates for the Diplomas of the English, Scotch, and Irish Colleges of Physicians and Surgeons, amount to £67.

**Anderson's College Medical School, Glasgow.**—New and excellently equipped buildings were opened in October, 1887, in Dumbarton Road, immediately to the west of the entrance to the Western Infirmary, and within four minutes' walk of the University. Extensive laboratory accommodation is provided for practical anatomy, practical chemistry, practical botany, practical zoology, practical physiology, practical pharmacy, operative surgery. There are also provided a library and reading room, and students' recreation room. The buildings are constructed upon the most approved modern principles. The dissecting room is open in winter from 9 a.m. to 6 p.m., and in summer from 6 a.m. to 6 p.m. These students are assisted in their dissections by the professor and demonstrators, by whom daily examinations and demonstrations on the parts dissected are conducted. The supply of subjects is ample, and students are consequently provided with parts as soon as they may be ready for them. The dissecting room is provided with a complete series of dissecting specimens mounted in plaster of Paris illustrating the anatomy of the human body. There is also a large Bone Room, furnished with complete sets of painted and unpainted bones.

The Carnegie Trust pays the fees of students at Anderson's College on conditions regarding which particulars may be obtained from W. S. McCormick, Esq., LL.D., Carnegie Trust Offices, Edinburgh.

**Class Fees.**—For each course of lectures (anatomy, ophthalmic medicine and surgery, aural surgery, diseases of throat and nose, and mental diseases excepted), first session, £2 2s.; second session (in Anderson's College), £1 1s.; afterwards free. For the following practical classes, viz.: Chemistry, botany, zoology, physiology, pharmacy, first session, £2 2s.; second session, £2 2s. Operative surgery, £2 2s.; laboratory fee, 10s. 6d. Public health laboratory, £11 11s.; with lecture, £12 12s.

**Anatomy Class Fees.**—Winter: First session (including practical anatomy), £4 4s.; second session (including practical anatomy), £4 4s.; third session, £2 2s. To those who have had the necessary courses of practical anatomy, the fee will be £1 1s. Summer: Lectures and practical anatomy, £2 12s. 6d.

**Western Infirmary.**—Fees: Hospital attendance, £10 10s. (permanent); clinical instruction, winter £3 3s., summer £2 2s., pathology, £4 4s. (systematic), practical pathology, £3 3s.; vaccination, £1 1s.

**Royal Infirmary.**—Fees: Hospital practice and clinical instruction, first year, £10 10s.; second year, £10 10s.; afterwards free. Six months, £6 6s.; three months, £4 4s.; pathology, both courses, £4 4s.; vaccination fee £1 1s.

**Dental Curriculum.**—Students studying with a view to the dental diploma can obtain instruction in the following subjects: Physics, chemistry, anatomy, physiology, surgery, practice of medicine, and materia medica. The special dental courses may be obtained in the Dental School, 5 St. Vincent Street, Glasgow.

#### POST-GRADUATE COURSES IN SCOTLAND.

In Edinburgh a number of post-graduate courses continue more or less throughout the year.

In Glasgow, special courses in ear diseases are held in November and May at Anderson's College, and Post-graduate courses in pathology and bacteriology at the University in autumn.

[END OF THE EDUCATIONAL NUMBER.]

A HANDSOME presentation was last week made to Dr. Arthur Pugh, assistant to Dr. O'Kelly, on the occasion of his leaving Chipping Norton.

THE Carlisle Board of Guardians have decided to retain a bed for a year in the new sanatorium for consumptives at Threlkeld, at an annual cost of £78, for the use of Carlisle Union cases.

## Notes on Current Topics.

### The Value of Examinations.

EVERY cloud has its silver lining, and it may somewhat soften the student's inevitable aversion to examinations to know that Sir Thomas Barlow considers them invaluable training for after life. In a speech delivered at the distribution of prizes at St. Thomas's Hospital in the summer, he pointed out that the practitioner's life was made up to a great extent of examinations, principally *vidu voce* ones. Patients, and especially patients' friends, fill up half the doctor's visit by questioning and cross-questioning, and ready replies which can be substantiated by facts and illustrated by examples constitute the practitioner's greatest asset. The art of the student under examination consists in persuading the examiner that he knows what he is talking about, even if his real information is comparatively slender. The general practitioner who can do the same to his patients is marked out for success, and generally achieves it. The *vidu voce* examination provides excellent training in the art of smartly answering questions that come somewhat unexpectedly, and Sir Thomas Barlow thinks that they also help to banish one of the greatest hindrances to the young doctor, namely, self-consciousness. It is a comfort to think that the gentlemen on the other side of the table who smile superciliously on the stammering candidate are really his dearest friends, and that the incredulity that sometimes characterises their glance at the victim, far from being intended to pain him, is merely a method of encouragement in disguise.

### Medical Thinking and Medical Thought.

THERE is a great tendency in this busy age to reduce all the processes of life to a severity of form of the Gradgrind order. Everything is stripped of its trappings, and the essential alone is preserved. Newspapers give their news in brief paragraphs; the shorthand writer is replacing the confidential secretary; drugs are compressed into "tabloid" form. The same influence is apparent in what is usually termed the practical side of medical education. The student must be taught this, that, or the other, because he may need it; such and such a subject must be dropped out of his curriculum as it has ceased to be useful. A certain amount of well-considered change is inevitable if useful progress is to be made, but there is a great danger in the coaching and cramming that students have to undergo to meet the demands of the modern examiner that he will seldom come into touch with medical thought—at any rate, in its best and highest exercise. It is no disparagement to the up-to-date physician to say that he has not the time to devote to thinking that his old-fashioned predecessor enjoyed, and that what he gains in scientific method is, to a certain extent, acquired at the expense of scientific thought. The work-a-day man has to have another man to do his thinking for him, and to furnish him with the results. At least, so one is often led to suppose.



when instituting comparison between this age and former ones. There can be no doubt, however, that much, if not all, of the real pleasure of medical work is sacrificed by those who fail to enter into the spirit of medicine when they assume its practice. The student who wishes his life's work to be an intellectual pleasure under all conditions should take the earliest opportunity of placing himself on familiar terms with what we may call the mind of medicine. He cannot accomplish this better than by the study of the works of some of the old masters in medicine, who are still models on which all sound practice may be fashioned. Every student should buy such a book as "Graves's Clinical Lectures," or Sir Thomas Watson's "Principles and Practice of Physic," the first day he enters the hospital, and read it through once a year. By the time he is qualified he will have no difficulty in judging which is the best book on his shelves, and which gave him the greatest insight into medical thought.

#### The Voice of Authority in Medical Studies.

To a young man fresh from school the greatest danger of the early years of medical study lies in his disposition to take the word of his teachers for law. The tradition of all scholastic establishments is to magnify the pedagogue and to keep the pupil under, so that the latter comes to regard the opinion of his instructor as the last word to be said on each particular subject. So, too, with his books. The authors of the commentaries and treatises on which he is nurtured are mystic abstractions who knew all about the matters of which they write. If the student is ever to become a scientific man in the true sense of the word, he must, from the start, cultivate a respectful disrespect for everybody's word about the phenomena he observes, and never accept any statement that he is not able either to verify himself, or to find cogent evidence in favour of. Every fact in chemistry, anatomy, physiology, and medicine is capable of verification by observation or experiment, and in so far as in him lies the student should not let one pass without endeavouring to satisfy himself that it rests on a solid foundation. Dogmatism has no place in medical study. The student may have a high regard for the opinion of his teacher, but he should never be satisfied till he has followed all the steps through which that teacher's mind passed before arriving at the final conclusion. A schoolmaster may be very impressive in enunciating a law in mathematics, knowing that his position is unassailable—the law is an old one that has been demonstrated over and over again; but the scientific teacher is at the mercy of his pupils if he is "cock-sure" about anything without having proved it for himself. The darkest period of medicine was from the day of Galen to the day of Harvey; the period when all medical knowledge was centred in the works of the great writers, and every case was treated by the application of the methods recommended in those works. No name, however great and justly honoured, should be allowed to be a guarantee for a single fact that the medical man can find out for himself; authority has a very back seat in the domain of medicine. The student's training is not derived from reading books, but from finding out if what his books say is true.

## Correspondence.

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

### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I only have to refer "A Country Practitioner" to my original address for the following, which contains a sufficient answer to all his questions:—

"My own opinion is that while occasional abstinence (or continence) in married life is perfectly allowable and may have, as I have suggested, a high moral hereditary value, no artificial prevention is advisable save that which is produced by operation, when deformity or grave disease imperatively demands it."—Page 23 of published address.

I have no reason to alter or qualify this in any way.

I am, Sir, yours truly,

JOHN W. TAYLOR.

22 Newhall Street, Birmingham.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It seems to me that the national importance of this question more than justifies the prominence you have lately accorded to it in your columns. This intricate problem cannot be solved off-hand by the *ipse dixit* of any individual, no matter how distinguished he may be in other branches of scientific work. Nor will the matter be advanced by the triumphant detection on one side or the other of minor errors in the arguments of the protagonists of the discussion. The question was most ably raised by Dr. Taylor, and his views have been clearly if somewhat forcibly criticised in the article subsequently contributed by Dr. David Walsh to your columns. There can obviously be only one solution. Dr. Taylor is either right or wrong in his views that the fall in the birth-rate is due mainly to preventive practices among married folk, and that such practices are productive of the greatest moral and physical harm. If he is right he should be able to meet all criticisms that are brought forward in a clear and logical way. He has laid down the law in tones of such strong conviction that he owes it to his reputation to sustain his propositions with ample and adequate proof. Meanwhile, I trust the matter will be thoroughly threshed out in THE MEDICAL PRESS AND CIRCULAR, the only medical journal which has had the courage to bring this most important social problem to the front.

I am, Sir, yours truly,

DUNS SCOTUS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The original paper of Dr. Taylor was widely quoted and commented on in all our church journals, and I certainly gathered from their perusal that he said the diminishing birth-rate was due to certain restrictions practised among married people. These practices he condemned utterly and said that they wrought incalculable harm both upon parents and children that were born in spite of them. His main text was that married folk ought to have as many children as possible, and that claim he advanced without any reference to the means or social position of the parents or to the upbringing and the future of their offspring. I then wrote stating my position as a poor curate's wife, who has had to keep house and bring up three children on an annual income of £250. I asked Dr. Taylor if he thought I ought to have brought an unrestricted number of children into the world "on the strength of social and intellectual qualifications that fail to furnish the decencies of life reasonably demanded by my husband's station in society." I am much disappointed at Dr. Taylor's reply, which is to the effect that he has not enough data to say whether I ought to have married or not. That is not the point. I am married, rightly or wrongly, and I want to know how his rules apply to my case.

I am, Sir, yours truly,

A POOR CURATE'S WIFE.

## 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.

### NOTICE TO HOSPITAL AND COLLEGE DEANS.

The Editor desires to thank those gentlemen attached to the various Schools and Hospitals for supplying him with the information from which the foregoing pages have been composed.

### NOTICE TO OUR READERS.

As this number is mainly devoted to information necessary for students intending to join one or other of the various medical colleges, and for those who, having passed their curriculum, are about to enter the ranks of the profession, much of the ordinary matter which usually fills our columns is necessarily deferred till next week.

### GRATUITOUS COPIES.

A VERY large number of copies of this issue are being sent gratuitously to all the educational establishments, hospitals, reading-rooms, clubs, and large hotels in the United Kingdom, and to a large number in America, India, the Colonies, and on the Continent; should any of our readers desire to present a copy to a patient or friend who contemplates sending his son to a medical school, our publisher will be happy to supply him with a duplicate free of cost on receipt of address.

LETTERS from our Paris, Berlin and Vienna correspondents, and several communications from others, are unavoidably held over this week on account of the space devoted to educational matters.

### EPSOM COLLEGE—ELECTION TO FEMALE SCHOLARSHIP.

AN election to a Female Scholarship at this College will shortly take place, notice of which will be found in another column of this issue. Candidates must be between the ages of 7 and 13, and must be necessitous orphan daughters of duly qualified medical men who have been for not less than five years in independent practice in England or Wales. Form of application can be obtained at the office of the College, 37 Boho Square, W.

DR. Y. J. S.—You need not have any hesitation in using anti-phlogistine under the circumstances you mention. We believe it is an excellent preparation and should be glad to hear of the result in this particular case.

### POISONING BY OLEANDER, OR ROSE-BAY.

THIS beautiful flowering shrub which is such a prominent feature in the gardens of southern Europe possesses well-marked toxic properties and these are often turned to account by soldiers desirous of obtaining a furlough. A handful of leaves are infused in boiling water and the solution swallowed. In a case recently observed by Dr. Bonnette, in south Oran, the symptoms commenced with nausea, vertigo, prostration and a fall of temperature to 97° F.; the extremities became cold, with dilatation of the pupils, loss of pupillary reflex and anesthesia of the cornea. The heart became irregular and the pulse slow and thready with gasping breathing, constipation, and mental confusion merging into coma. These symptoms lasted throughout one day and recovery set in with green diarrhoea and a copious excretion of dark urine. The heart remained slow for some time after.

### A LEGAL VIEW OF MEDICAL PRACTICE.

The following anecdote was overheard recently at the Medico-Legal Society's Rooms.

The following is told of the late Lord Morris, when examining a veterinary surgeon at Coleraine.

"Now tell me this. The 13 grains—wouldn't they teetotally kill the devil himself if he swallowed them?"

The witness was annoyed and pompously replied:

"I don't know, my lord. I never had him for a patient."

From the bench came the answer:

"That's true, no, docter, sure and ye never had. More's the pity. The old bhoy's still alive."

### THE DIMINISHING BIRTH-RATE.

A CORRESPONDENT asks if the Birth-rate is diminishing throughout the United Kingdom, or only in certain localities. We have looked into the latest returns of the Registrar General to hand which include the eighty largest towns of England, Ireland and Scotland, and find the increase is pretty general but more marked in the largest cities. In Greater London with its vast suburban population the births during the last week were 651 below those of the corresponding period for the last ten years. As an offset to this, the deaths were 152 below the average.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, SEPTEMBER 14th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. H. I. Barnard, Clinique. (Surgical.)

THURSDAY, SEPTEMBER 15th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchison: Clinique. (Surgical.)

FRIDAY, SEPTEMBER 16th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Paton: Clinique. (Eye.)

## Vacancies.

**Birkenhead Borough Hospital.**—Junior Resident House Surgeon Salary £80 per annum. Applications to the Honorary Secretary, Birmingham General Dispensary.—Resident Surgeon. Salary £75 per annum, with furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

**French Hospital and Dispensary, 173 Shaftesbury Avenue, W.C.**—Resident Medical Officer. Salary £80 per annum with full board. Applications to the Secre ary.

**Halifax Union Poor-law Hospital.**—Resident Medical Officer. Salary £120 per annum, with apartments, rations, and washing. Applications to Arthur T. Longbottom, 4 Carlton Street, Halifax.

**Hereford County and City Asylum.**—Assistant Medical Officer. Salary £150 per annum, with furnished apartment, board, and laundry. Applications to the Medical superintendent.

**Horton Infirmary, Banbury.**—House Surgeon. Salary £80 per annum, with board and residence in the Infirmary. Applications to the Honorary Secretary, 31 Marlborough Road, Banbury.

**North Cambridge Hospital, Wisbech.**—Resident Medical Officer. Salary £100 per annum, with furnished rooms, attendance, coal gas, and washing. Applications to William F. Bray, Secretary.

**Royal Berkshire Hospital.**—House Physician. Salary £80 per annum, with board, lodging, and washing. Applications to the Secretary.

**St. Mary's Hospital, Paddington, W.**—Medical Officer in charge of "X" Ray Department.—Salary £150 per annum. Applications to Thomas Ryan, Secretary.

## Appointments.

**BAMFYLDE DANIELL, G. W., M.B.C.S.Eng., L.R.C.P.Lond.**, Anaesthetist to the Edinburgh Dental Hospital.

**BULLIPE, ARTHUR, L.R.C.P., L.R.C.S.Eng., L.F.P.S.Glasg.**, Medical Officer for the Hearts of Oak Friendly Society at Midmore Norton (Somerset).

**GRAHAM, JOHN, B.Sc., M.B., Ch.B.Glasg.**, Resident Assistant in the Victoria Infirmary, Glasgow.

**HOOLE, JOHN, M.B.C.S.Eng., L.S.A.**, Medical Officer of Health to the Ashbourne Rural District.

**LEWIS, S. WOLSELEY, M.D., F.R.C.S.**, Medical Superintendent of the Kent County Lunatic Asylum, Barming Heath, near Maidstone.

**McLAREN, GEORGE H., M.B.C.S.Eng.**, House Surgeon to the Birmingham and Midland Eye Hospital.

**NAPIER, A. HARPER, M.B., Ch.B.Glasg.**, Resident Assistant in the Victoria Infirmary, Glasgow.

**POLLOCK, ANDREW M., M.B., Ch.B.Glasg.**, Resident Assistant in the Victoria Infirmary, Glasgow.

**SHARPE, EDWARD S., M.B., Ch.B.Édin.**, Junior Assistant House Surgeon to the Stockport Infirmary.

**STANFUS, H. S., M.B.Édin., M.B.C.S.Eng., L.R.C.P.Lond.**, Senior Ophthalmic House Surgeon to St. Thomas's Hospital.

**THOMSON, J. WHITE, M.B., Ch.B.Glasg.**, a Resident Assistant in the Victoria Infirmary, Glasgow.

## Marriages.

**HUMBY—BETH.**—On September 10th, at Nicol Road Presbyterian Church, Hatfield, Daniel Morgan Humby, L.D.S., M.B.C.A., L.R.C.P., to Edith Muriel, eldest daughter of A. T. Betts, Esq., of Hatfield.

**KENNEDY—BABINGTON.**—On September 7th, at St. Paul's Church, Gleneagary, William Player Kennedy, M.D., Gay Street, Bath, second son of A. D. Kennedy, Esq., Glen-na-geragh Hall, Kingstoven, to Alice Frances L'Estrange (Allie), youngest daughter of the late William W. Babington, Esq., B.A., of Cork, and Mrs. Babington, of Dunluce, Gleneagary, co. Dublin.

**KIRBY—TURLE.**—On September 8th, at St. John's Church, Whetstone, N. Laurence, second son of the late Frederick Baker Kirby, and of Mrs. Kirby, of Torrington Park, North Finchley, to Elizabeth Margaret, third daughter of James Turle, M.D., of North Finchley.

## Deaths.

**CARVER.**—On September 7th, at Torquay, Edmund Carver, M.D., late of Cambridge, aged 80.

**CHALMERS.**—On September 11th, at Leighton, Southborough, Esq., widow of the late David Chalmers, M.D., of Everton, Liverpool aged 78.

**DICKINSON.**—On September 6th, at Trebrea Lodge, Tintagel, William Lee Dickinson, F.R.C.P., elder son of W. Howship Dickinson, F.R.C.P., of Trebrea Lodge, and 10 Stanhope Place, London, aged 40.

**DUDGEON.**—On September 8th, at 23 Carlton Hill, N.W., Robert Ellis Dudgeon, M.D., in his 85th year.

**RIORDAN.**—On September 9th, at Roseville, Ireland, Gertrude, dearly-loved wife of Lt.-Colonel J. Riordan, R.A.M.C., B.I.P.

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## Original Communications.

### HOSPITAL ISOLATION OF SCARLET FEVER: THE DESIRABILITY OF AN INQUIRY INTO ITS EFFECT.

By MEREDITH YOUNG, M.D., D.P.H.,

Medical Officer of Health, County Borough of Stockport.

THE hospital isolation of scarlet fever has been practised for so long, and has become such a routine preventive medicine prescription, that it seems almost heresy to entertain the slightest doubt as to its effective value. At the same time the benefits of the procedure have been most seriously questioned by a number of men of standing in the Public Health Service, and the arguments and statistics adduced by them in support of their contention, though vigorously assailed, still stand in the main uncontroverted. To the perfectly open mind the supporters of hospital isolation have, up to the present, done little more than effect what the eulogistic Russian war-correspondent would term "a masterly retreat." There are doubtless many who, like the writer, would gladly welcome a verdict in favour of the isolation hospital, provided that it was the genuine outcome of an exhaustive and independent inquiry. But the present position is that of Mahomed's coffin—half-way between heaven and earth—and it is a most disconcerting and disappointing one.

In my own town of Stockport, with a population of 100,000, a sum of about £20,000 has been spent during the past sixteen years on the isolation of scarlet and typhoid fevers alone, and the former disease has monopolised quite three-quarters of the available hospital accommodation; roughly speaking, therefore, the hospital treatment of scarlet fever, the utility of which both to the community and to the individual is so seriously questioned, costs this town on an average £1,000 per annum, and appears likely to cost more.

Thousands upon thousands of pounds of public money continue to be expended upon this doubtfully useful measure. And there can be no question but that local authorities are frequently so handicapped financially by this expenditure on hospital isolation that other public measures of indubitable benefit are passed by.

The wholesale and indiscriminate removal to hospital of scarlet fever cases is a measure not without other drawbacks than those mentioned by Dr. Millard and his followers. For example, it tends to weaken the sense of individual responsibility and leads to the relaxation of those proper

precautionary measures which should be taken by every householder on the outbreak of infectious disease in his family; and particularly is this the case when everything is done for the affected household free of expense. The wretched and far-reaching apathy which such a measure inculcates could not be better illustrated than by the words of a mother who had three children ill of measles, and who remarked to the writer that "she wished it had been scarlet fever, because they took them to the hospital for that and there was no bother with them then."

Dr. Millard, as is well known, has made a careful and thorough inquiry, and has published an abundance of statistics to show that hospital isolation has failed to materially reduce the prevalence or fatality of scarlet fever. Dr. James Niven, who has probably conducted a more elaborate inquiry into the question than anyone else, is forced to the conclusion that whilst hospital isolation of scarlet fever has reduced its prevalence in Manchester, "the reduction was not so great as could be desired." (Annual Report, 1901.) Numerous other practised observers have recorded varying opinions and collected valuable statistics. Evidence on all the main points and many of the side issues is thus already to hand, and much more would be abundantly forthcoming if some authoritative and independent body would undertake to formulate the most useful lines of investigation, and subsequently collate and analyse the material. Scarlet fever has been isolated more than any other disease for about twenty years, and therefore there should be a mass of useful and interesting evidence available at comparatively short notice.

Clinical, pathological, and bacteriological investigation is still required to make the story complete; and if the investigation be conducted on proper lines discoveries of the utmost importance might be the result. The etiology of scarlet fever is still obscure; its *causa causans* yet remains hidden; its variations in type and epidemicity are explicable only by the flimsiest conjecture; the prevention of return cases, the transmission of otorrhœa and rhinorrhœa, the causation of post-scarlatinal nephritis, the persistence of infectivity and a host of other matters require elucidation. We have abundance of evidence as to the occurrence of complications in hospital-treated cases, but to what extent have we similar evidence in respect of the home-treated cases? What evidence, again, have we at present of the occurrence of "return" cases outside the patient's own household? To these and many other associated problems there can surely be

found an answer if a proper stimulus to research be only given.

The main, if not the sole, objection to an inquiry into this matter is that it may "shake public confidence." But has not the confidence of the medical profession and of thinking laymen already been shaken? And is not the best manner to restore that confidence to court the fullest investigation and to search out the truth, whatever it may be, rather than to plunge our heads ostrich-wise into a mass of unconvincing statistics and empty platitudes?

The matter is one of considerable urgency, for many local authorities are now hesitating as to the adoption of isolation hospital schemes, in the hope that those of the profession on whom they rely for advice in such matters will adequately defend their theories or forswear them.

Would it not be wisdom also to somewhat extend the scope of any inquiry which may be held, and to ascertain whether there are any disadvantages attendant on the hospital isolation of diphtheria and enteric fever?

Dr. E. D. Marriott has suggested (*Lancet*, vol. i, 1902, p.1078) that in the Boer War hospital "aggregation" played some part in the disastrous diffusion of enteric fever. If there be any truth in this, would it not be well to learn it at once?

It is by no means an easy matter to say by whom the inquiry could best be conducted, if it be undertaken at all. The body to which probably most of those interested looked for a lead (the Incorporated Society of Medical Officers of Health) has on more than one occasion given evidence of its desire to avoid responsibility—to put the thing at its mildest. Moreover, this body is composed of experts, and an inquiry by experts into their own principles and practices would savour of the Gilbertian. If one were given a choice, one would unhesitatingly pronounce in favour of a Royal Commission or a Select Committee, for in this way one would certainly secure what is required—that is, men accustomed to weigh evidence calmly, to find a common-sense way through mazy arguments, and to sift statistics, whilst it would be possible to secure on such a body the very necessary services of one or more experienced general medical practitioners. Moreover, the verdict of a Royal Commission would undoubtedly carry weight with both professional men and laymen.

In conclusion, if some body is appointed to investigate this vital question, is it impudent or impertinent to draw their attention to four most excellent rules drawn up for the guidance of statisticians by Quetelet?

"1. Never have preconceived ideas as to what your figures are to prove.

"2. Never reject a number that seems contrary to what you might expect, merely because it departs a good deal from the apparent average.

"3. Be careful to weigh and record *all* the possible causes of an event, and do not attribute to one what is really the result of the combination of several.

"4. Never compare data which have nothing in common."

THE examination of the rats found on board the steamer at Hamburg from West Africa, which were believed to have died of plague, shows that this suspicion was without foundation. The discharge of the cargo has, therefore, been continued.—*Reuter*.

## FAMILY CARE OF THE INSANE. (a)

(A VISIT PAID TO GARDELEGEN IN NOVEMBER, 1903.)

By DR. C. WICKEL,

Principal Medical Officer at the Provincial Asylum of Meseritz, Posen.

TRANSLATED, WITH THE AUTHOR'S PERMISSION,

By CONOLLY NORMAN, F.R.C.P.I. (b)

At the first International Congress for the Relief of the Insane, with a special view to their Nursing Care in Families, held at Antwerp on September 1st, 1902, Alt, in his paper, stated that his chief reason for establishing family care in Gardelegen was to demonstrate that even at home in Germany this mode of treatment can be naturalised without a preliminary education of the population extending over many years, and, further, to show that suitable patients would be happier living in a family than even in an institution like Uchtspringe, where freedom of treatment is carried to the highest conceivable point.

At the present time, after family care has existed for five and a half years at Gardelegen, it can be said that the experiments made there, and the results obtained thereby, furnish a most full and complete proof of the justice of Alt's anticipations.

On an excursion which I took for the purpose of acquiring information in the autumn of 1903, it was my privilege to become familiar, from my own observations, with family care as carried out in Gardelegen, and I am happy to be able to report thereon in this place.

In the autumn of 1898, the first patients, namely, four women, were transported from Uchtspringe to suitable families in Gardelegen. In April, 1901, eleven female patients were sent. From that date forward, the number of cases in family care has increased rapidly and almost uninterruptedly, reaching the figure of 119 (chiefly female patients) in January, 1904.

The patients at Gardelegen are to be regarded as belonging to the institution of Uchtspringe. More than two patients are not committed to the care of any family at the same time. The number of families who act as hosts is constantly increasing. Only an exceedingly small number of such families have proved themselves unsuitable for the care and watching of patients. The return of patients to the institution necessarily takes place in some cases in which severe bodily illnesses or mental exacerbations occur.

In the year 1903, a head nurse was stationed at Gardelegen. The medical care of the settlement was at first managed solely from Uchtspringe. In the summer of 1903, a special physician was appointed who resides in Gardelegen, and takes charge of the patients in family care under the director (medical superintendent) of Uchtspringe, Dr. Alt. Dr. H. Stamm, who had familiarised himself at Gottingen, as physician to the asylum there, with the institution of family care, received this post.

Gardelegen, like the asylum at Uchtspringe, is situated on the Stendal-Hanover Railway, fourteen kilometres (between eight and nine miles) distant from Uchtspringe, or about twenty minutes' journey by train. It is a pretty, cheerful, little country village, the chief town of its district, having about 8,000 inhabitants. It has nice clean streets and solid well-built houses. On the whole, it gives a certain impression of prosperity.

Round the town and corresponding to the old fortifications and earthworks, run pleasure grounds and promenades. A handsome avenue leads out of the old town towards the new along which lie a few villas, but chiefly strongly built, decent, one-storey houses. A well-kept garden is attached to most of these houses. In this locality almost every house contains a patient.

(a) As this paper refers to one of the more recent German institutions for family care, which has attracted a good deal of attention abroad, I think this rendering of it may have some interest to the readers of THE MEDICAL PRESS AND CIRCULAR.—O.N.

(b) From Bresler's *Psychiatrich-Neurologische Wochenschrift*, June, 1904.

Gardelegen has no general water supply. The water comes from public pump wells. It is unobjectionable. The general sanitary condition of the town is very good. Infectious diseases seldom visit it, and typhoid especially has not appeared for a succession of years.

The number of houses open to receive patients is very considerable. Hereby is clearly seen how great an interest the population already take in the family care of the insane. I myself had several opportunities of confirming this by my own observation. A villager came to the house of the doctor while I was there and begged to be given a patient. He declared he would take all possible trouble, and that he had already prepared a room in accordance with regulations and under the advice of other hosts. Owing to the precautions which are adopted in the choice of applicants and to the great number of applications that had been already made, it was necessary at first to advise him to wait. Indeed, before a family receives a guest, the most exhaustive inquiries are prosecuted as to the calling and the character of the family, as to their employment, and particularly as to the conditions of their dwelling with special reference to hygiene. How completely this is done the paper of questions provided for this purpose, and which is appended hereto, will serve to indicate. In the dwelling of a family of hosts who had received patients for some time and were known as specially good at the work, people who even assisted the others with their advice, the wife of another host was waiting for the doctor and begged urgently that he might give her a patient once more. On the day before, in fact, her patient, who was a case of periodic mania, had been brought back to Uchtsprunge on account of a return of excitement. The woman was now afraid that perhaps she would be blamed for the re-appearance of excitement, and that in consequence no other patient could be entrusted to her again. She repeatedly represented that she would thus be disgraced "before the others." In company with the doctor, I visited the very great majority of the quarters where patients are maintained. Throughout, the dwellings were clean and well kept. The rooms set apart for the patients were faultless in their condition, roomy, clean, open to light and air, cheerful and provided with clean bedding. In case a room was not in absolute order, the family were always eager to excuse themselves and explain the reasons. Frequently more furniture was found in the patient's room than the regulations required. We saw some rooms which obviously were specially constructed or renovated for the reception of patients. These rooms were exhibited by the families with a certain pride.

When we visited a lodging, some member of the family immediately appeared holding a book which contains the rules about family care, which is also used for the memoranda of the doctor and of the head nurse as to the time of the visit, the medical prescriptions, the notes about clothing, renovation, improvement, &c. It also contains special columns to indicate the occurrence of the menses, the body-weight, and occasional convulsive seizures. Almost in every case the master or the mistress of the house was present. In Gardelegen, indeed, there is a great deal of home industry, particularly the preparation of mother-of-pearl. Therefore the inhabitants are not often absent from home. The hosts seemed good-natured, accommodating, and intelligent. Almost all of them reported without suggestion on the condition of their patient as to bodily state, occupation, and occasional alterations in mind. A master tailor communicated his observations about his patient, a child, *æt.* 8, in a very clear way such as would have been creditable to any trained attendant. The matter in question related to attacks of *petit mal*, appearing for the first time in an idiot boy.

The patients themselves came forward or were brought in from their work. They were, without exception, well cared for, clean in person and clothing, under and upper. Their condition of nutrition was very good. They all looked contented. Many of them seemed very happy. From the behaviour of the members of the family and from the attitude of the patients, it could

be concluded that their relation with each other was a friendly one. This was very noticeable when the patients were still children. In such cases, indeed, it frequently seemed that relations similar to those between parents and child existed.

In most cases the patients were employed in the kitchen peeling potatoes, washing, and the like, or they were helping the woman of the house in sewing. This, of course, was in accordance with the preponderance of female patients. Some of them accompanied the woman of the house on her journeys to the yard in care of fowl, &c. Others who were incapable of occupation sat in the common room with the members of the family. Some young patients were met on the street, watching the children of their hosts at play or taking part in their games. I asked a number of patients in the usual way whether they would not rather go back to Uchtsprunge, and whether Uchtsprunge was not a prettier and better place. In no case did I receive an affirmative answer. They all preferred remaining with the family of their hosts.

I will never forget with what joyful alacrity one worthy old lady, one of the eldest of the Gardelegen hosts, described the steps in the mental development of her patient whom she produced for inspection. In well-chosen language, she reported that the patient, when delivered over to her care some years before, could neither speak nor be induced to occupy herself, and even had sometimes to be watched closely with regard to cleanliness. Gradually the patient became more lively, began to occupy herself under constant instruction and verbal direction, learned, in the course of time, to sew and to darn, and is now a useful helper to her hostess in the house and at her work. The patient speaks little, but intelligibly. This was a case of idiocy, who is now *æt.* 19. Granted that in this patient perhaps a certain further development of the mental faculties might have taken place even in an institution, yet there can be no doubt that we must assign a great part of the striking and far-reaching result to the more genial influences of the family and to the exertions of the hostess and her belongings. According to the statement of the doctor, similar instances of the favourable influences exercised upon the mental condition of the patients in family care at Gardelegen have been repeatedly observed.

In a trusty and experienced family, a press for bandages and other dressings is kept. Any minor surgical dressing, &c., which is required is carried on there. Instruments and other surgical necessities for special cases are kept in the doctor's residence. Provision is made for bathing. A host's family has erected a little building in the yard attached to their holding, where there is a water supply and a tank with arrangements for warming water and two enamelled baths. In an ante-room to the bathroom a weighing machine is placed. Every four weeks at furthest each patient comes here in company with some member of the family and has a bath and is weighed. The host who built the bath-house and has to look after the machinery receives 30 pfennige (a little under 3d.) for each bathing, which is paid by the asylum. The baths and the weighing machine are also asylum property.

Eight of the guests belonged to the better classes, three ladies to the first and five to the second. Every two paying patients of the second class have a large and well-furnished parlour and a bedroom in common. Every lady of the first class has a sitting-room and a bedroom to herself. In a family whose house is situated in the street leading to the new town, two of these ladies live, old cases of chronic paranoia. They possess a prettily furnished bedroom and a large comfortable living room between them. The head nurse is provided with lodging in one of the better families. She takes her meals together with a lady of the first class.

Nearer the middle of the town, in the vicinity of the church square, a woman who was formerly an inspector of schools, and who lived alone, had a very good and nicely furnished dwelling of considerable size. Two ladies live with her who are also old-standing cases of chronic paranoia. The hostess devotes herself

entirely to her two patients. She cooks for them, looks after their apartments, and goes for walks with them.

In a shopkeeper's family a young imbecile lady was taken care of. She had two handsomely furnished and spacious apartments. She appeared quite contented, and announced that she was going in the evening with her host's family to the circus. The doctor told me that this patient could not get on at all at home, and was very troublesome in the institution, but had done remarkably well up to the present in family care.

It has never been observed that a patient was overworked, or made game of, or worried by the inhabitants of the town. Absolutely no untoward event worthy of mention has occurred up to the present in connection with family care in Gardelegen.

When patients of the third class (public patients) are admitted to the institution at Uchtspringe, their relations are required to signify beforehand that they agree to the transfer of the patient to family care, if such a course should be considered desirable having respect to the nature of the case. With regard to patients of the first and second class, relatives are asked in each particular case whether they consent to the patient being placed in family care. Since a special physician has been on the spot, this consent has always been gladly given. Furthermore, individual relatives of patients of the third class who at first had doubts about the placing of their people in family care became perfectly content with this method after they knew that there was a doctor in residence, and at their visits they expressed their complete satisfaction. In connection with this I may be allowed to make a brief observation upon some points which make it apparent how valuable the presence is of a medical man devoting himself entirely to family care and living on the spot. The doctor learns to know more thoroughly not only his patient but also the family of the host by the intimate and almost daily intercourse that he has with them, and he is thus in a better position to utilise the peculiar qualities of the people for family care. He is able to commit to them particular patients according to the foresight and cleverness shown in particular cases, and he can thus individualise better in the location of his patients; but, above all, the constant interest of the doctor in the patient calls forth from the host and his family a correspondingly heightened interest. By commendation of particularly excellent guardians, by reference to the example of others, and by the eventual removal of a patient who is hard to manage to a more able guardian, and the substitution of one that is easier to manage, emulation is kept alive among the hosts. Without doubt, a rivalry of this kind, a certain competition, an effort to do their best, at present exists among the families of the hosts in Gardelegen, and this is a very desirable thing in the interests of the patients. Very notable in this connection is the expression already referred to of the woman who feared she would be disgraced "before the others."

Alt has already shown in the most striking way how much always depends upon the cleverness and activity of the physician in the introduction and successful development of family care. It is scarcely necessary to particularly mention here that the choice of the patients who are to be committed to family care needs the most skilful consideration.

With reference to the forms of mental trouble in the persons committed to family care in Gardelegen, congenital and acquired conditions of weak-mindedness come first, and also old, quiet paranoiacs, forms of disease which are already recognised as being eminently suitable for family care. (α) The following table gives details:—

Forms of Disease.	Grown-up Patients of		Children of	
	Male Sex.	Female Sex.	Male Sex.	Female Sex.
Paranoia .. .. .	2	27	—	—
Imbecility, Milder Forms of Idiocy .. .. .	11	51	2	20
Epilepsy .. .. .	1	3	—	—
Periodic Insanity .. .. .	—	1	1	—
Total .. .. .	14	82	3	20

It is in contemplation to erect, in the course of time, a little central hospital in Gardelegen for the reception of patients who are temporarily excited, or who suffer from severe bodily illness. In the central hospital an examination room and a room for drugs and surgical necessities and bathing accommodation will be provided as well as a residence for a head attendant. Family care would thus be carried out around a small infirmary as at Jerichow, according to the plan designed by Alt, and called by him the German system of family care.

A visit to the family care settlement at Gardelegen presents a highly cheerful picture of earnest, active, successful progress. We here behold a practical experiment in family care on a large scale which has been crowned with success, such an experiment as is well designed to be an example, and to serve as an example. May it contribute to excite further that interest in family care of the insane which, up to the present, has been constantly increasing in Germany, and may it tend to smooth the way for the freest and most natural of all methods of relief for the unsound of mind.

The communications which the Medical Superintendent, Dr. Alt, made to me with reference to maintenance cost may be of interest. "The cost of clothing including boots and shoes, and including the renewal of articles worn out during the year, amounts to 77 pfennige per head daily. The amount spent on repairing shoes in the last year ran to 0.3 pf. The income of the physician stationed at Gardelegen, and of the head nurse set apart for looking after the patients, amount respectively to 10.6 and 4.4 pf. The latter charges will, of course, diminish proportionately with the increase and extension of the system. The cost of medicines has heretofore been at the lowest, amounting to about 0.25 pf. Tobacco is not given by the institution to patients in family care, who very often receive tobacco and cigars from their hosts as an encouragement to work, or reward for work accomplished. The total cost of a patient at Gardelegen by the day amounts to a certified expenditure of from 80 to 102.65 pf. The latter figure, is, therefore, about 17.35 pf. lower than the maintenance in the asylum for a grown-up patient (a third-class patient at Uchtspringe costing 1 mark 20 pf. per diem), and very much cheaper than the total cost of a patient in the asylum. According to last year's balance sheet, the total cost of a patient in the institution amounted to 172.19 pf. per diem.

"The family care of patients of the better classes, on the other hand, offers unmistakable advantages compared with asylum care, inasmuch as, for the paying patients at present in Gardelegen—three ladies of the first class and five of the second—7.75 marks daily less is paid out than is received."

Without further argument, these details show clearly that to the many other advantages which it brings with it we must, in deciding upon the question of the family treatment of the insane, add a considerable pecuniary profit which can by no means be put in the last place.

In conclusion, I must here again express my warmest thanks to the medical superintendent, Dr. Alt, for all the kind help he has given me, and also to Dr. Stamm, who showed me round.

#### APPENDIX.

List of Questions to be considered in allocating patients to family care:—

(α) The number of persons in family care in Gardelegen has risen from 119 to 142. Seeing that here are in addition 62 patients in the attendants' village at Uchtspringe and in the neighbouring villages, and that there are besides in Jerichow and its vicinity 146 patients located in families, it is to be observed that at the time of the writing of this paper the number of persons in family care in the province of Saxony has already attained to 360.



1. Full name of host? Address? Age? Religion? Married or Widowed? (age of wife or housekeeper). 2. Total number of members of household? (a) children? number, age, sex, employment; (b) lodgers, servants? 3. Employment or trade of the host? Is there constantly a member of the family at home? 4. Do the family live in orderly comfortable conditions? Do their means of subsistence come from their own industry? 5. What is the general impression which the family makes? 6. How does it stand with regard to orderliness and cleanliness (of dwelling, clothing)? 7. Does any suspicion exist of drink or tuberculosis? Have any cases of mental disease appeared among the family? 8. Why do the family wish to take charge of patients? How many do they want, and of which sex? Do they express any other special wishes regarding them? 9. How is the holding situated? (enclosed by other holdings or by dwellings in the neighbouring streets). 10. Of what does the holding consist? (offices, byres, arable). 11. How is the arable situated? the garden? 12. Do the family own cattle? (horses, goats, pigs, fowl). 13. Water supply? Where is the well situated? Is the water good and well flavoured? Where is the cesspool? 14. Privy? 15. House? (brickwork, timber, cellar, roof, architectural condition). 16. Dwelling of the family? (No. of rooms, ground plan, kitchen, &c.). 17. Where does the family spend the day? Living room, eating room (size, air, light, heating, aspect, floor, furniture). Are there beds in the living room? 18. Sleeping rooms of patients? (a) Air space (area of floor, height of room); (b) No. and size of windows, aspect, light; do the windows look out on the street or yard? have they movable sashes? (c) How do the doors lead? (d) Walls? (how covered, hangings, dryness); (e) articles of furniture? (f) Floor (covered? cellar underneath?) (g) Ceiling? (h) Heating? (i) Bed? 19. Are there any other dwellings under the same roof? If so, who occupies them? Occupier's trade, number of children, sex, age; servants, lodgers, other members of family; moral character. 20. Report, if such be forthcoming, from someone who can vouch for—(a) general respectability (character, repute, mode of bringing up children); (b) domestic circumstances of the family.

### Paris Clinical Lectures.

## THE MEDICAL TREATMENT OF CANCER OF THE STOMACH.

By PROFESSOR ALBERT ROBIN, M.D.,

Member of the Academy of Medicine; Professor Agrégé at the Faculty of Medicine of Paris; Physician to the Paris Hospitals.

I DREW your attention just now to a man, æt. 65, in the Serres ward, pointing out to you that his extreme emaciation and the straw-yellow hue of the skin were suggestive of the existence of a neoplasm. As a matter of fact, he is suffering from cancer of the pylorus. For a year past he has suffered from loss of appetite and progressive enfeeblement; he complains of pain in the region of the stomach associated with vomiting of glairy material mixed with food. I will take advantage of this case to discuss the symptomatology of gastric cancer, and more particularly its treatment.

The onset of carcinoma is, as a rule, insidious and gradual. The principal symptom is loss of appetite, with repulsion for particular articles of food, such as meat and wine. Nevertheless, one occasionally meets with cases in which the appetite is increased instead of diminished. Vomiting is one of the most constant symptoms of gastric carcinoma, and is due to the situation of the growth at the orifices, to disturbances of the

chemistry of digestion and the irritation caused by the presence of the growth itself. The most characteristic sickness is that which occurs on rising on an empty stomach, or during the day, preceded or accompanied by extreme nausea. The vomit consists of glairy mucus, which is brought up without effort, as it were by mere regurgitation, the so-called "cancer brash." In some cases the vomiting is purely alimentary, the food being returned some hours after meals, with great relief to the patient, whose stomach is thus emptied of its contents. These may be returned unaltered, but usually there is fermentation, and the vomit has an acrid or putrid odour. Under the microscope we see sarcinæ, numerous micro-organisms and, according to Boas, one long bacillus in particular, to which some authorities accord a special diagnostic value. There is an absence of hydrochloric acid, and there is only a minute quantity of peptone, while, on the other hand, fermentation acids are present in abundance. Acid fermentation is much more common in gastric carcinoma than gaseous fermentation. Lastly, we get the so-called "coffee-ground" vomit due to the presence of altered blood that has oozed from eroded vessels. This may be accompanied by melæna or not, and melæna, on the other hand, may exist without coffee-ground vomit. Copious hæmatemesis is exceptional in gastric carcinoma, and its occurrence points rather to gastric ulcer. Another cardinal symptom is pain. This is very common, but it is far from being as acute as in ulcer. Cancer patients do not suffer much from acute attacks of pain; they complain of a feeling of weight with occasional sharp pangs over the growth, which is tender to the touch. They are rarely free from this distressing sensation, even between meals; it is not at once increased by the ingestion of food, but gradually increases in intensity as digestion proceeds, with some pyrosis.

Severe pain on palpation of the tumour indicates the existence of partial perigastric peritonitis. Really severe pain, however, is rare and occurs only when the fibres of the pneumogastric are involved by the growth. Intestinal troubles are common, constipation being the rule, diarrhœa supervening only in the terminal stage.

The exact situation of the neoplasm may often be determined by palpation. In the case before us there is a prominent, diffuse hard tumour on the anterior surface. The stomach is not distended, and this shows that the pylorus is intact. To complete our investigation we must have an analysis of the stomach contents. Some years ago the absence of free hydrochloric acid was regarded as pathognomonic of cancer of the stomach, but this is not the case, since it may be wanting in many other affections, as, for instance, chronic gastritis, hyposthenic dyspepsia, &c. Moreover, in some cases of gastric carcinoma the acid is not only present, but is present in excess, and I have noted this in eleven out of 250 cases of the kind. Nevertheless, the point is one to be observed, because the absence of acid may confirm a suspicion based on other inconclusive facts. When present in excess the probability is that the cancer has supervened on an ulceration of long standing. Lactic acid is usually present, and in Germany its formation was at one time declared to be a distinctive sign. This, however, it is not, for it is absent in a quarter

of these cases, and, on the other hand, is met with in simple dyspepsia.

Leucocytosis seemed likely at one time to afford us valuable information in this connection, but experience has not confirmed this conclusion, in short, our diagnosis must be based on the clinical examination of the patient, not only of the stomach, but also of the other organs, in which there may be metastasis, or which may be secondarily involved by the gastric affection. The liver in particular must be carefully explored as well as the omentum, the peritoneum and the umbilicus. Look out also for enlarged glands above the left clavicle, which, if present, possess grave significance, in that they contraindicate surgical intervention. In the case before us there are no enlarged glands. Lastly, examine the lower limbs to see if there be oedema or possibly *phlegmasia alba dolens* of the veins of the calf. The examination of the urine affords no assistance.

Among other complications the most frequent, after those already mentioned, are affections of the broncho-pulmonary apparatus. Then, too, there may be a rise of temperature, brief, irregular or intermittent, attacks of fever, due to the absorption of the toxic products of gastric fermentation. Sometimes the temperature remains above normal, a form of septicæmia. We can do nothing to control the two last, but the first variety yields to the administration of antiseptics. Lastly, we may get various symptoms of intoxication—coma, tetany, polyneuritis, and so on—but these are altogether exceptional.

In view of the advances that have been accomplished in the surgery of the stomach, one is apt to suppose that the *rôle* of the physician herein has disappeared. Nothing of the kind. We may concede that medical treatment holds out no prospect of recovery, that it can at most attenuate the more distressing symptoms and mitigate the causes of the pain. Moreover, we meet with cases which are inoperable by reason of the extreme enfeeblement of the patient, and who, by appropriate medical means, may so far regain strength as to become able to withstand an operation.

I need hardly tell you that the curative treatment of cancer has yet to be discovered. Still it is useful that you should be told of the various remedies that have been tried because even if they do not cure, they are sometimes very useful palliatives and adjuvants. Condurango, for instance, used to be highly thought of, though in reality it is really a tonic bitter. It is still given as a tincture or fluid extract. Iodide of sodium, methylene blue, and bichromate of potash, in doses of from a fifth to one grain, conium, tincture of thuja, &c., &c., have all been tried, but I have never obtained any results worth speaking of. I have not experimented with various anti-cancer sera, but those who have done so do not appear to have much to say in their favour.

Some years ago Fiessinger and Jaboulay claimed to have obtained great benefit from muriate of quinine in the treatment of cancer in general. The treatment is applicable to the treatment of cancer of the stomach, and in my hands it has certainly appeared to delay the progress of the disease and to mitigate some of the symptoms. Later on I will compare the results of this treatment with those of surgical intervention.

Muriate of quinine is administered by the mouth,

by the rectum, or hypodermically. The average dose is 16 grains a day. It is best given by the mouth, but sooner or later the stomach becomes intolerant. *Per rectum* it ultimately excites tenesmus, and subcutaneously it is painful. Consequently, my plan has been to alternate the three modes. For eight days I give twice daily in the epigastric region an injection of, at first. ℞ ℞, then ℞ cxx of a solution of ʒvi of the salt in ʒxij of sterilised distilled water. During the next eight days I give 8 grains of the salt in cachet form, either fasting or a short time before food or milk, and a like quantity in suppository, just before bed-time. Then I return to the injections, and so on. If tolerance supervenes towards one method of administration we make up the dose by the mode that is still tolerated. In some patients we can give as much as 20 or even 30 grains daily, but this is exceptional.

Muriate of quinine seems to me to be one of the best palliatives, and under its influence I have often witnessed a remarkable improvement. I reinforce the action of this salt by associating it with two other products which appear to me to exert a favourable influence in retarding the evolution of the disease, *viz.*, arrhenal and bromide of gold. Arrhenal in 5 per cent. solution is given in 10-drop doses twice daily for five days. Then for another five days I give a tablespoonful of a solution containing one grain of bromide of gold in 10 ounces of water. Such is the fundamental treatment of carcinoma, a plan which, it is true, gives very modest results, but which will nevertheless bear comparison with those of surgical intervention as usually practised.

The next important point to consider is that of alimentation. There is a tendency when gastric cancer is diagnosed forthwith to place the patient on milk diet. This is often a mistake. There are cases in which milk diet is appropriate and others in which it is not. We may put on the strict milk diet patients with gastric intolerance or pyloric obstruction, those who have an insurmountable distaste for food, and lastly, those who suffer from hæmatemesis. The quantity must be adapted to the capacity of the particular patient, and every means must be employed to ensure its being tolerated.

In deciding the question of what food to give, you must be guided by the state of the intestines. If the intestinal functions are more or less disturbed they will be unable to make up for the inadequacy of gastric digestion, consequently we must discard meat, which excites repulsion, and insist on a vegetable diet, selecting substances rich in nitrogen in order to maintain as far as possible the intake of nitrogeous matter. If, on the other hand, the intestinal functions are in fairly good order we may order a mixed diet adapted to the state of the stomach. Under these conditions, by getting the patient to eat he can be kept going for a tolerably long time. To get him to eat, however, we must give him an appetite, and it is here that we must have recourse to bitters. Among the so-called "apératifs" or appetite-givers is the persulphate of soda. It must be given in weak solution, and stopped as soon as the appetite begins to return; in any case, discontinue it in eight days (persulphate of soda, gr. xxx, distilled water, fl. oz., x. A tablespoonful half an hour before lunch and dinner). Metavanate of soda is another good appetite-restorer.

(Metavanate of soda, gr.  $\frac{1}{2}$ ; distilled water, one pint; dose one tablespoonful.) Failing success, you can try a combination of the tinctures of gentian and quassia with jaborandi and nuxvomica. When you have induced the patient to eat you must assist the digestion, since we cannot trust to his unaided powers. You will, therefore, prescribe hydrochloric acid and digestive ferments—pepsine and malt during the meal and a keratinised pill of pancreatine after the meal.

Fermentation must be controlled by the administration of fluoride of ammonium (fluoride of ammonium, gr. v; distilled water, fl. oz., xij. A tablespoonful with lunch and dinner). When the fermentation causes pain and vomiting give a teaspoonful of the following mixture immediately after eating and another as soon as the pain begins: Subnitrate of bismuth, i drachm; carbolic acid, 15 drops; chloroform water, 4 fl. ounces. If the pain be very severe you may order occasionally a teaspoonful of the following: Cocaine muriate, i grain; codeine, i grain; lime water, 5 fl. ounces; chloroform water, 1½ ounce. In presence of intense pain apply a blister to the epigastrium, and powder the raw surfaces with powdered opium. If the pain be caused by acid fermentation giving rise to pyrosis, prescribe the following powder: Precipitated chalk and hydrated magnesia, aa i drachm; soda bicarb., 1½ drachm. Mix and divide into twelve powders, one to be taken as required.

Then for the vomiting, when persistent, put the patient on a strict milk diet, and before each drink of milk give him 4 or 5 drops of the following solution: Picrotoxine, i grain; rectified spirit, q.s. to dissolve; hydrochlorate of morphine, i grain; neutral sulphate of atropine, gr.  $\frac{1}{4}$ ; ergotin Bonjean, ℥ 16; cherry laurel water, ℥ 180. If nothing whatever can be tolerated, abandon the milk and nourish the patient by rectal enemata. This course is also advisable when there is hæmatemesis. Among other tonics I may mention subcutaneous injections of glycerophosphate of soda in 5-grain doses daily for a month.

Our patient is obviously in a very bad way. Nevertheless, since his admission a week ago he has gained some 25 ounces in weight. Of course, he cannot recover, but do you suppose that surgical intervention would give a better result? According to recent statistics pylorotomy or gastrectomy gives an operative mortality of about 26 per cent. The immediate results of the operation are indisputably admirable in such patients as survive the operation, the digestive functions improve, the pain subsides and they gain in weight. Unfortunately, the improvement is not of long duration, and if the lymphatics are involved, which is the rule, the growth recurs in other organs, and death supervenes from recurrence, cachexia or metastasis. Most of such patients under my own observation have succumbed to broncho-pulmonary complications. The average period of survival is one year, and by purely medical treatment the average period is eight months. Under these circumstances I really hardly care to expose the patient to an operation that kills three patients out of ten, on the off-chance of obtaining a prolongation of life for three months. You will bear in mind that the surgical is the best treatment when cancer can be diagnosed with certainty. In one case, under Doyen, the patient survived three years and a half,

and in that instance we were unable to agree upon the diagnosis quite at the onset. The tumour was removed in its entirety and life was prolonged beyond anything that medical treatment proper could offer. Such cases, however, are exceptional.

Our patient is too feeble to bear such an operation. One might perform gastro-enterostomy, but the operative risks are just as great and the operation would only relieve the pyloric stenosis. When successful this operation sometimes procures an improvement in the symptoms and an increase in weight, but the strength does not return, and the characteristic yellow colour of the skin persists. That is not surprising, since the operation has not removed the cancer, and has for object merely to prevent gastric stasis. The disease runs its course, and the patient is carried off by one or other of the complications. Such patients do not live longer than those who refuse operation.

To sum up, there is no curative treatment of carcinoma, but there is a palliative medical treatment which enables us to prolong life for considerable periods. In any event, if we do not markedly prolong life, we are in a position, with the means at our disposal, to assuage the patient's sufferings and to imbue him with a certain hopefulness. It is only in the painful cases, where the means I have described fail to afford any relief, that we are justified in having recourse to gastro-enterostomy, which, in my opinion, will always be in the nature of an exceptional operation.

## British Health Resorts.

### X.—FALMOUTH.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

AMONG Cornish health stations Falmouth very rightly occupies a foremost place. This picturesque old port, sheltered on the west side of its extensive and much indented harbour, has won the enthusiastic advocacy of such distinguished physicians as Sir Joseph Fayrer and Sir Edward Sieveking; and medical men in all parts of the country have testified to the benefits of this highly favoured resort on the Cornish Riviera.

The situation, conveniences, and climatic conditions are such as peculiarly fit the place for a winter residence. The abundant and semi-tropical vegetation affords clear evidence of the mildness and equability of the climate. Falmouth in the summer months is for many persons undoubtedly enervating; and even in late spring we have found it distinctly relaxing. But for the aged and the infirm, the delicate and the convalescent, and particularly for the subjects of chronic respiratory affections Falmouth can supply much that is of the greatest benefit. For those enfeebled by years or the attacks of disease this sheltered, old-fashioned marine residence provides protection from the stress of winter weather and allows of the maintenance of a fairly free open-air life throughout the year.

Falmouth possesses an important Meteorological Observatory, and its records extend from the year 1867. These returns clearly indicate the prevalence of climatic conditions particularly desirable for the physically feeble. Much sunshine is enjoyed, the temperature is equable, and the mean of the maximum and minimum temperatures is about 50°; the mean range being between 9° and 10°. The air possesses peculiarly balmy qualities, and there is good protection from winds. Sharp frosts are almost unknown, and such fogs as occur are generally free from irritant properties.

Endless interest circles about the spacious bay, the well-protected harbour, and the winding river Fal. The immediate district is rich in places of historic and natural interest. The town and vicinity offer much that is pleasing to artist and antiquary. Persons of all tastes will find in Falmouth congenial material for study.

The hotels, viewed from the standpoint of health-seeker and invalid, leave much to be desired, but good apartments are always available.

We have carefully studied the health resources of this resort, and consider it particularly adapted for the special requirements of those who, from the wear and tear of years or the encroachments of disease, require a peaceful, regulated, equable and protected life. For chronic invalids it can offer many attractions. It is, however, perhaps most useful as a winter residence for chronic bronchitis, sufferers from laryngeal affections and those who are the subjects of chronic tuberculous and other slowly progressive forms of pulmonary disease. Patients with chronic renal disease should do well in Falmouth; and some forms of nervous derangement may be expected to gain benefit from residence in this quiet town.

It is not for us here to describe the many attractive features which the enterprise of man has added to the benefits so richly provided by Nature: (a) it suffices to say that much has been accomplished to meet the requirements of the health-seeking visitor.

Falmouth is 306½ miles distant from London. The Great Western Railway run excellent trains in a little over seven and a half hours. (b)

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, September 18th, 1904.

### TREATMENT OF ACUTE RHEUMATISM.

THE classical treatment of acute rheumatism has been for years salicylate of soda. It acts on this affection as a specific, like mercury on syphilis and quinine on intermittent fever.

In 1876, Stricker proclaimed the efficacy of salicylic acid, already tried by Buss, of St. Gall. But it was Germain Lée who, a year later, in a memorable communication to the Académie de Médecine, indicated the rules of the treatment of rheumatism by salicylate of soda.

Not only should the treatment be prescribed at the outset, but if the fever be high, large doses should be given—two drachms daily. For children, a drachm should not be exceeded. Salicylate of soda irritating the stomach, it is best given in Vichy water or in a mixture, as—

Salicylate of soda, ʒiij.

Rum, ʒj.

Syrup of orange water, āāʒiij.

From two to eight tablespoonsful a day.

The treatment should not be suspended with the cessation of the pain; to insure durable effects it should be continued in decreasing doses for fifteen days.

Salicylate of soda is toxic for some patients. The intolerance is shown by nausea, vomiting, vertigo, and sometimes by heart troubles, which may terminate in syncope.

The drug also provokes congestion of the kidneys; by accumulating in the economy it gives rise to grave

(a) See "Old Falmouth." By S. E. Gay. (London: Headley Bros.) The Corporation of Falmouth issue a useful guide. (London: The Health Resorts Association.) Messrs. Ward, Lock and Co. have published a useful guide which contains much data regarding meteorological conditions. A useful table respecting the climatic state of Falmouth appears in "The Climates and Baths of Great Britain." (London: Macmillan and Co.) Vol. I., p. 55.

(b) See "The Cornish Riviera." Published by G.W. Railway, Paddington, W.

toxic accidents when the function of the renal organs is compromised. Thus, when a patient suffers from chronic nephritis, salicylate of soda should not be prescribed. The same may be said of those suffering from arterio-sclerosis, from heart disease, and in pregnant women by reason of its abortive properties.

In all these cases, other drugs may be prescribed with more or less benefit.

It is thus that *antipyrim*, recommended by Masius Bernheim, can be substituted. It is prescribed in daily doses of forty-five to sixty grains. It relieves the pain and lowers the temperature, but it has not the specific action of salicylate of soda.

*Salol* and *salophen* have been given by many, while *aspirin* seems to be very efficacious and well tolerated; but, according to Dr. Gerest, *pyramidon* is equal in its effects to salicylate of soda. He administers it in doses of five grains every six hours or every four hours, according to the intensity of the affection, and continues it eight days after the fever has yielded.

Generally, he says, from the day following the administration of the pyramidon, a great improvement in the local and general symptoms takes place; the temperature falls almost completely, and gradually the physical signs disappear.

No accident of any kind was ever observed during the treatment; the only inconvenience is the production of sweating, but few patients complain of it, and in any case it diminishes rapidly, although the drug is continued. However, it would be well to abstain from giving it to consumptive and diabetic patients; in the former on account of the sweating, and in the latter because it increases the quantity of sugar eliminated by the urine.

### BLEEDING HÆMORRHOIDS.

The following will be found thoroughly trustworthy in this troublesome complaint:—

Cocaine, gr. ¼.

Solution of adrenalin (1 in 1,000), o.m.

Antipyrin, grs. v.

Cocoa butter, q.s.

For one suppository.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 18th, 1904.

In the *Korr. Bl. f. Schweiz. Aerzte*, Bd. 14, 1904, is an article on

### PRIMARY PERITONITIS IN INFANCY,

by Dr. E. Döbeli. He records a case observed by himself of primary purulent peritonitis, and remarks that he has been unable to find more than five other cases recorded in literature. His own case was that of a boy, 11 weeks old. It had been suckled by the mother from its birth to within four days of the commencing illness. The child was fed five times in the twenty-four hours, and vomited after every meal. It had three to four normal stools daily. The child had been very restless for some days before being taken to the polyclinic.

On December 26th the state was as follows:—Slightly furred tongue, temperature 37° C., weight 5 kgrm. The child was put to the breast and drank 40 grm. on the following day. The general condition had got worse—temperature 39° C., weight 4.900 kgrm. For the next few days the secretion of milk returned to the breast, so that the quantity sufficed for the infant. Constant vomiting at first of milk, then of bile matter. January 1st.—The child had not taken the breast from the day before. The last stool was on December 31st.

The kidney excretion ceased, and the child cried constantly. Face pinched, somnolence, continued vomiting of bile matter, but nothing fecal. Extreme meteorism, dulness in the dependent parts. The child cried aloud when its abdomen was touched. The vomiting not so severe after washing out of the stomach. There was a suspicion that an abscess had burst into the peritoneum, but the desperate condition of the child would not permit of any surgical interference. The child died at six in the evening.

The autopsy showed purulent peritonitis. On opening the abdomen a large quantity of thin, odourless pus mixed with lymph flakes escaped. The whole peritoneum, especially that over the visceral parts, was much injected, and showed numerous fibrinous deposits. The mesenteric glands were swollen. There was scarcely any other pathological sign; there was no perforation, the vermiform and its neighbourhood and also that of the umbilicus, were normal. The spleen was not enlarged, the liver and kidneys were healthy. The case was diagnosed as one of diffuse purulent streptomycotic peritonitis.

In a case described by Netter, in a child, a day old, there was also meningitis. The excitors were pneumococci. Also in a case of Perrin's, there were pneumococci in the pus.

In the cases adduced the infection most probably took place from the intestines. The danger of the passage of bacteria from the intestine into the blood was greatest in the first days of life. The so-called puerperal infection of children was most frequent during puerperal epidemics. Of course, any peritonitis starting from the umbilicus would easily be recognised.

In the *Arch. f. Experim. Path. und Pharmak.* is a paper by Breuer and v. Seiller on  
THE INFLUENCE OF CASTRATION ON THE BLOOD OF THE FEMALE.

The authors have endeavoured by way of experiment to determine the question of the influence of the ovaries in connection with chlorosis. As the thyroid and suprarenal capsules have undoubtedly an influence on tissue change, so the ovaries have been thought to have an influence in certain anomalies of constitution. Independent of their function of evolution, they have been credited with another function, that of an internal secretion that is capable of influencing tissue changes.

Experiments were made on young female animals by depriving them of their ovaries, and the experiments showed that the loss caused a decided change in the quantity of the blood in the form of diminished blood corpuscles and lessened quantity of hæmoglobin.

The diminution in the blood was only a passing one, and after a time the function of the ovaries appeared to be taken up by other organs. Whether the poorness of the blood in blood corpuscles was due to over-destruction or diminished regeneration could not be determined.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 18th, 1904.

### ANOMALOUS FORM OF JACKSON'S EPILEPSY.

At the Bohemian meeting in Prague, Vitek showed a man, æt. 17, who, eleven years ago, suffered from meningitis, which was followed by hydrocephalus. The first attack of Jackson's epilepsy occurred at the onset of the meningitis and repeated itself at intervals afterwards, always becoming shorter. The contractions commenced in the right lower extremity, gradually rising to the right upper extremity and right side

of the face, while the eye was twisted towards the left.

The most interesting point in this case was the invasion of insensibility, unconsciousness, biting of the tongue, involuntary passing of water as well as other genuine symptoms of epilepsy. It might be mentioned that after this meningitis amaurosis with atrophy of the papilla set in.

His interpretation of the course of the disease was that the meningitis in the first attack was the result of an inflammatory encephalic process of the central convolution, whereby an adhesion of the meninges and grey cortex of the brain became united. Finally, hydrocephalus formed in the subarachnoid space, tearing up the adhesions and increasing the number and severity of the attacks.

### GOUTY PARALYSIS.

Thomayer gave a very instructive *résumé* of the paralysis of gout, which, he affirmed, assumed very mysterious manifestations, occurring in the hands of the neuro-pathologist as epilepsy, hallucinations, aphasia, and paraplegia, which disappear as soon as the gouty symptoms appear. These phenomena are met with everywhere, and need not be described, although it might be pointed out that there are four varieties of this gouty condition requiring close observation.

The first and common form is where the paralysis recedes as soon as the gouty symptoms develop; the second has the paralysis concurrent with the gouty symptoms and disappears with them; the third has the paralysis long after the gouty symptoms have disappeared; while the fourth has the most peculiar anomaly of all by having paralysis of one extremity at the same time that the patient is suffering excruciating pain in the opposite extremity.

All these forms of paralysis must be recognised as temporary neuritis without disintegration of the nerve fibre, having their origin in a toxic agent acting on the periphery of the nervous system. It should be borne in mind that this toxic substance is not to be found in the urine no matter how careful an analysis has been performed. The speaker assured his hearers that he had repeatedly injected the urine of these patients into frogs and failed to elicit any symptom of the poison.

### SACH'S AMAUROTIC IDIOCY.

Heveroch presented two sisters, æt. respectively 2½ and ¾ years, with a family tendency to idiocy. The children, he related, were quite normal and healthy at birth, and continued so for six months. About this time convulsions appeared, which were followed by squinting and inability to steady the eyes or recognise anyone, although the development still went on. The muscles were soft and paretic, but not atrophied. Neither of the children could sit up after this time; neither could creep or walk, but lay helpless performing purposeless movements. Spasms occurred either voluntary or from external stimuli. Neither of them had evidently any sense of hearing or smell, although taste seemed to be present. No trace of intelligence was to be observed. The parents were perfectly healthy, but the history of the father's side was not satisfactory, where there was a history of alcoholism, epilepsy, hydrocephalus, and arthritis deformans to be found.

Both of these children differ from Sach's type of the disease in (1) being the offspring of Catholic children and not Mosaic; (2) the absence of the characteristic macula lutea hypercausis and sense of smell; and, lastly, one of the children had passed its second year without any promise of improving.

## EVOLUTIO PRÆCOX.

A large number of these precocious children are described as *menstruatio præcox*, but Jaroslav drew special attention to a child, æt. 6½, which he showed to the members as a remarkable case of premature development. At its birth it was much larger in size than its other two elder sisters, and also grew rapidly after it was born. In its fourth month the breasts became swollen, with a sanguineous discharge from the vagina; at the sixth month this was repeated, and has recurred regularly since every four weeks, continuing to discharge for three or four days at the period. The only exception occurred two years ago, after an attack of scarlet fever, when the menses were suppressed for six months. At the age of one and a half the hair was a considerable length on the pubes and in the arm-pits. The child now weighs 25½ kilos, or 4 stone 3 lbs., and measures in height 127 centimetres, or 4 feet 2 inches, and has all the appearance of a girl of 13 or 14 years of age. The breasts measure 14 centimetres in diameter, half spherical mammilla, well formed and dark coloured around, well nourished and the hymen *in situ*. The labia majora are pigmented and full; and *per rectum* a large uterus can be detected with a very large irregular spherical left ovary. The pelvis is wide; and the skiagraph gives a picture of a perfectly developed female of 18 years. The epiphyses of the ossia femoris are quite hardened, and the pelvic bones perfectly ossified and bound together. The pelvis measures: Distantia bi-spinalis, 24½ centimetres; bi-cristalis, 25 centimetres; bi-trochanterica, 24½; and the conjugata externa, 15 centimetres.

Jaroslav said the causes for these precocities were recorded as many, but few had the record of this case to show. Among the etiological factors were rickets, tuberculosis, bacterium coli, stimulating diet, heredity, and, finally, primary hyperplasia of the ovary.

## DILATATION OF COLON.

Braun showed a specimen of a dilated colon, which he had taken from a patient on whom he had operated for a distended sigmoid flexure which had hitherto defied every therapeutic device of injections, puncturing and stimulating. He concluded that operation and resection gave the best results in all such cases.

Wredel did not think that every case required such operative treatment, as he had recently treated three such cases of dilatation, although one had to be resected.

Madelung said he preferred laparotomy as a radical cure.

## INTUSSUSCEPTION AND OPERATION.

Israel described a case of intussusception which he had endeavoured to treat with water and air injections, but the invaginated bowel could not be kept from repeating the dislocation, which necessitated operation on the fifth day, after which the patient made a perfect recovery. Since then he had operated on two others by an extraperitoneal method, and left an anus preternaturalis, both of which seemed to be doing well.

## The Operating Theatres.

## ST. BARTHOLOMEW'S HOSPITAL.

OPERATION FOR PERFORATED GASTRIC ULCER IN A MALE.—MR. McADAM ECCLES operated on a man, æt. 28, who for two years had had continued indigestion with gradual loss of appetite. The patient was seized with an exacerbation of pain soon after his mid-day meal on the day before admission. He

vomited, but the ejected matters contained no blood. He immediately became somewhat collapsed, and had very great difficulty in reaching the hospital from his home, a quarter of a mile away. On admission, his pulse was 64, his temperature normal, but his respirations were somewhat quickened. The abdominal walls were held rigid everywhere, but especially so in the epigastrium. Pain over this region was very severe and radiated to the back of the left shoulder. The liver dulness was present, and there was no sign of free fluid in the abdomen. There was some uncertainty as to the diagnosis, but within a few hours from admission his temperature had risen to 101.6°, his pulse to 94, and his respirations to 28. Further, his liver dulness had given place to a resonance, and there was marked rigidity over the upper half of the abdomen. Mr. McAdam Eccles decided to explore. An incision was made four inches long in the middle line above the umbilicus. The extra-peritoneal tissue was œdematous. Gas escaped when the peritoneum was opened. The anterior wall of the stomach, which was not adherent to the parietes, was bathed with gastric contents. A small perforation, the size of the uncut end of a cedar pencil, was found close to the pylorus, but definitely to its left. The stomach wall in its neighbourhood was much thickened, and the surrounding peritoneum injected, and covered with a flake of lymph. Owing to the induration of the stomach wall about the site of the perforation, there was much difficulty in closing it because of the silk Lembert sutures tending to cut out. After some time, however, a satisfactory plication was accomplished, and an omental graft stitched over it. A thorough cleansing of all the surrounding area was carried out by sponging. No flushing was used. The wound was closed in the upper portion, but the lower was packed with sterile gauze. Mr. Eccles remarked that there were several points of considerable interest in the case. In the first place there was the fact that the patient was a male, for gastric ulceration in men is distinctly uncommon, and a perforated gastric ulcer extremely rare. Duodenal ulceration and perforation, he pointed out, were not so unusual in males. Again the extreme pain with intense rigidity of the upper part of the abdominal wall was a feature of great importance in the diagnosis, and this practically decided him in performing an exploration. The fact that the abdomen was opened and the aperture in the stomach wall found and sutured within six hours of perforation was greatly, he said, in favour of recovery. In the majority of perforations of the gastric and duodenal walls he believed it to be safer to simply plicate with Lembert's sutures, placed well beyond the site of perforation as well as over it, rather than to excise the ulcer and restore the continuity of the wall. The omental grafting also helped to secure good union. He considered that unless there was extensive extravasation of gastric contents, it was better to merely wipe out the escaped material and to avoid free flushing, which had a tendency to distribute rather than evacuate the irritating matters. It was not well, he thought, in these cases to completely close the abdominal wall for fear of possible leakage, and, therefore, a gauze drain should be left for the first few days, and its presence for that period would but slightly retard healing of the wound and convalescence.

The patient made an uninterrupted recovery.



## CANCER HOSPITAL.

**OPERATION FOR OBSTRUCTION OF THE PYLORUS.—PYLOROPLASTY FOLLOWED BY FURTHER CONSTRICTION.—GASTRO-ENTEROSTOMY.**—Mr. BOWREMAN JESSETT operated on a woman, æt. 46, for obstruction of the pylorus. The patient came to the hospital first in January, 1903; she then complained of constant vomiting, which had lasted more or less for two years; she could retain nothing. She had lost four stones in weight, at this time weighing seven stones. The stomach was greatly dilated and a somewhat hard mass could be felt to the right of the umbilicus. The succussion note was very distinct. The general aspect showed pinched features, with an anxious look, and the woman was very emaciated. There was little or no pain. She never had had hæmatemesis. Mr. Jessett opened the abdomen in the middle line between the ensiform cartilage and the umbilicus, withdrew the stomach and examined the pylorus, which was found to be thickened. He next made an opening in the stomach about two inches from the pylorus and passed in a finger. He could find no growth, but an old ulcer partly cicatrised was seen at the back of the pylorus. He could barely get the tip of the little finger into the pyloric orifice. He decided to perform pyloroplasty. The patient made an excellent recovery and remained well for some nine months, when the old symptoms began to return. Her weight was then eleven stones; since then she gradually lost two stones. She came to the hospital again fifteen months after the first operation. Her weight was then nine stones, and she had been suffering from constant pain. She had vomited up about half a pint of dark fluid three months previously. Mr. Jessett advised her to come into the hospital to have gastro-jejunostomy performed. This was done a month after. An incision was made in the right linea alba, and a loop of jejunum withdrawn through the opening with the stomach; these were united first by a circular continuous suture extending round the posterior parts, and through the serous and muscular coats. A free opening was then made into the bowel and the stomach, and the cut edges united by continuous suture passing through all the coats of both viscera. The suture which had united the serous surfaces was then continued round the whole opening. A few stitches were passed through the serous and muscular coats of the proximal end of the jejunum, fixing the gut to the stomach wall to prevent kinking. The abdominal wound was united in three layers, and the patient returned to bed. Mr. Jessett said that this case illustrated very well what many surgeons had reported—namely, that strictures of the pylorus operated on by pyloroplasty are very apt to become constricted again. It was interesting, he thought, to see how the patient had improved in general health and weight for nine months after the first operation; then the pyloric orifice again became constricted, and the old symptoms recurred, so that he would advise in all such cases that a gastro-jejunostomy should be performed in the first instance.

Six months after the last operation the patient is well.

THE influence of a fine September has already made itself felt in the mortality returns in a marked manner, both in town and in country.

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, SEPTEMBER 21, 1904.

**HOSPITAL ISOLATION AND SCARLET FEVER.**

THIS week we publish further contributions on the supposed value of isolation hospitals as preventives of scarlet fever, and we commend the arguments used to the judgment of our readers. They confirm the conclusions reached by the writers in the last two numbers of THE MEDICAL PRESS AND CIRCULAR, namely, that the whole subject of the utility of these hospitals is ripe for full and free investigation by an authoritative body. We hope to publish further communications on the same question, as we feel that the matter is one on which every particle of information available should be forthcoming. All over the country large sums of money are being spent by municipalities on the construction and maintenance of these institutions; indeed, the hospital is one of the largest items of the sanitary budget, and it behoves medical men who are intimately connected with the scheme to see that the money is used to the best advantage. At present it may be gravely doubted, in view of the evidence brought forward, whether the community is wise to burden itself with the maintenance for a period of many weeks of thousands of cases of scarlet fever. Unless it can be shown that the procedure affords a marked degree of protection from the incidence of the disease—an assumption that is, to say the least, doubtful—it is difficult to contend that its benefit is at all commensurate with its cost. It must be clearly borne in mind that the aim of isolation hospitals is only incidentally philanthropic, and that they were not primarily instituted to afford relief to sufferers from infectious diseases. Had they been erected for that purpose, their founders would never have left severe cases of measles and whooping-cough—diseases far more prevalent and fatal than scarlet fever is at present—to be nursed and tended in back kitchens and garrets,

while mild cases of scarlet fever receive every attention in hospital. The aim of the hospitals was to abolish scarlet fever from our midst, or at least to reduce it materially, and by their ability to accomplish this end they must stand or fall. Certainly, in the opinion of some of our contributors, they have been but qualified successes. Then, too, as to certain positive evils of these hospitals. There need be no hesitation in saying that the evils of segregation have shown themselves to a greater or less extent in all the large fever hospitals, in spite of elaborate care in construction and skilful administration. On the other hand, information is forthcoming from many of the smaller institutions to show that such evils are practically unknown in them, and that cross-infection of patients is of the greatest rarity. The suggestion naturally occurs that whilst the small hospitals have been useful and advantageous, the larger ones have not been so, and here again we see a fruitful line for investigation. No sort of conclusion can be entertained unless founded on the most complete information and on the widest data available. It has been contended that every medical officer of health should make his own inquiries, and, having satisfied himself that his hospital is doing good in his district, should rest content in that assurance. Surely this is a selfish view to take of the matter. Some towns and districts admit partial failure and positive evils, and it is for those districts that are free from them to allow the knowledge of their advantages to become of general utility. The kind of information that is needed is so broad and so varied that no inquiry would be likely to be successful that was not undertaken, not only by acknowledged experts, but by men of authority whose disinterestedness and integrity were above suspicion. Such an inquiry should embrace questions of construction, site, and disposition of hospitals; their principles of administration and their arrangements for dealing with doubtful and complicated cases. Besides these points, the experience of this country with regard to scarlet fever should be compared with that of those countries that do not isolate scarlet fever, and different towns, and different parts of the same town, should be compared as to the incidence of the disease in them. It might prove that whereas it hardly paid the community to segregate all their scarlet fever cases, yet it might be well to continue with the isolation of those that occurred in dairies, public institutions, and closely-crowded quarters of towns. And, again, it might be held that, having a diminished number of cases to deal with, there should be arrangements at all large hospitals for separating patients from one another in cubicles, at any rate in the case of young children. Without associating ourselves entirely with the views expressed by all our contributors, we hold strongly that they have made out a good *prima facie* case for investigation, and we should be glad to hear that a strong representative committee had been formed for the purpose. A Royal Commission has been hinted at, but the question has

hardly reached the point of public interest at which a Government can no longer hold back, and we think in the meantime the work could be done better in many ways by medical men.

#### MEDICINE AND PATHOLOGY.

It has been a necessary result of the growth of the sciences which are auxiliary to the practice of medicine that their pursuit has fallen into the hands of others than the practitioners of the art. Only a few years ago the physician regarded it as his own duty to examine, let us say, sputum for suspected tubercle bacilli, whereas nowadays he rarely performs such examination. Similarly, the surgeon who required the help of microcology in the diagnosis of a tumour formerly cut his section and himself examined it; but to-day a surgeon would be considered rash thus to rely on his own opinion. In all such cases it is now the practice to refer the suspected material to an expert in pathology, whose report is to be regarded as one of the principal factors in diagnosis. Following on this splitting-up of duties that formerly fell to one person, there is naturally a certain narrowing of outlook. The physician is more purely a clinician than formerly, and the surgeon tends to become more of an operator. Each is content, to some extent, to leave pathology to the expert pathologist. At the same time, the latter subject has grown to such dimensions that the pathologist can rarely be intimate with the clinical side of disease. The consequence of this separation of spheres of work is often, unfortunately, a certain lack of appreciation in each of the work done by the other. The pathologist is too apt to form his conclusions without taking clinical considerations into account, and indeed the physician or surgeon often demands his opinion without giving him any help from the clinical side. Nothing can be more absurd than to expect a pathologist from pathological evidence alone to decide, for instance, the exact nature of a tumour. The clinical history, however, taken in conjunction with the microscopic appearance, may be absolutely diagnostic as between, say, a sarcoma and an inflammatory swelling, or between a malignant and an innocent growth. It is only by combining, as far as possible, the visions from the two points of view that good results will be reached. The physician or surgeon, therefore, should never send material to a laboratory without giving at the same time a concise clinical history of the case. We have heard, indeed, of a pathologist receiving a drop of blood on a scrap of paper, and being asked to decide whether the cow whence it came was tuberculous; and it is not uncommon to receive material in some strong antiseptic with a request for a full bacterioscopic examination. "Science is One," said Socrates, and, in so far as the student of any branch fails to realise the connection of that branch with the tree of knowledge, in so far does he fail as a man of science.

### THE LONDON HOSPITAL AND HOSPITAL ABUSE.

THE abuse of hospitals is one of the standing grievances of the general practitioner. That this discontent rests on a solid foundation can hardly be doubted by any candid onlooker acquainted with the facts of the case. The enormous attendance of out- and in-patients furnishes in itself sufficient internal evidence of the indiscriminate relief obtained at the great general hospitals throughout the kingdom. In spite of generations of complaint on the part of the medical profession the evil is growing by leaps and bounds, and has of late years been increased by the adoption of the pay system by various great general hospitals. Needless to say, the system of part payment is likely to multiply abuse by offering a salve to the conscience of well-to-do folk who might otherwise possibly entertain some lingering scruples as to the moral justification of their acceptance of alms intended for the sick poor. It is of some interest to ask why so little has been done to meet the demands of the general practitioner as regards the loss he sustains through the laxity of the hospital authorities in excluding well-to-do persons from the benefits of which they are the stewards. The causes are complex. First of all the medical charities and the medical profession do not work together. The hospitals are engaged in an internecine conflict and in efforts at self-aggrandisement. Many private and non-medical interests are wrapped up in these institutions, together representing an enormous annual expenditure of money. It is not too much to say that the aim—natural if not excusable—of all such persons is to swell the funds of the individual hospitals and secure the maximum number of patients, regardless of the medical practitioners outside. It is a serious matter that this attitude is positively supported by the honorary medical staffs, who are induced to give their gratuitous services to many in- and out-patients perfectly well able to pay the moderate fees of the general practitioner. Much more might be written upon the subject, but the tale is somewhat trite, and its chief points have been familiar to generations of medical men. The great self-evident want is that of organisation in all ranks of the profession for the purpose of common support and defence. The East End (London) Medical Association—a strong local combination—has shown what can be done by firm and united action. For many years the administration of charity at the London Hospital has been called in question. The answer of the authorities has always been to ask for proof of abuse and to deny the existence of the same in general terms. The Society mentioned has furnished a number of cases of abuse of the London Hospital by well-to-do persons. The authorities of the hospital have acknowledged the existence of such abuse and have appointed an almoner to sift cases. The further suggestion, however, that medical men should come to the hospital to identify patients appears to be about as ridiculous and unpractical as it would be possible

to expect even from a hospital committee. It is likely that from the circumstances of the case abuse at the London Hospital, situated as it is in the midst of a poor population, is less than at most of the great general hospitals of the Metropolis. Now that the ice has been broken and the first step towards justice and conciliation taken by the hospital authorities, it is to be hoped that in combination with the East End Medical Association they will readjust the relations of the London Hospital with neighbouring practitioners. It is to be hoped, also, that the Association will be enabled to banish a system of patients' payments recently adopted at that hospital—a fact which, in our opinion, constitutes a serious blot upon a great charity. Since the publication of the London Hospital disclosures certain interviews, apparently authentic, have appeared in the daily newspapers. They purport to come from stewards and secretaries of other great London hospitals. For the most part they deny the existence of hospital abuse; one of those interviewed contrives to give a good advertisement of the pay wards in his own hospital; all ignore the general practitioner in contemptuous fashion. That is the kind of attitude to which medical reformers have become accustomed. It is only by extending organised attack all along the line that the general practitioner can ever hope to come into possession of his birthright, of which he is at present more or less deprived by hospital competition. The East End Medical Association should be the model and example of local societies throughout the United Kingdom.

### Notes on Current Topics.

#### Hans, the Thinking Stallion.

THE art of training the lower animals to perform tricks has long been popular with mankind, and though these feats are primarily intended to astonish and amuse, they have in many cases a scientific interest for the anthropologist and even the psychologist. As a rule dancing dogs and curvetting cats merely bespeak a certain amount of sympathetic perseverance on the part of the trainer, reinforced, one fears, by the lash, and a certain litheness of the muscular system of the animal. The performances of the anthropoid apes stand on a different platform. Sally, the chimpanzee, was taught to count up to five, an accomplishment entirely lacking among the inhabitants of Damarland when Mr. Francis Galton visited them. Similar proofs of intelligence in animals are mentioned from time to time, and the upholders of instinct as opposed to reason do not stand on anything like so secure a foundation as they did five-and-twenty years ago. The most remarkable of animals, however, seems to be Hans, the thinking horse, as he is called, who has been astonishing Teutonic audiences for the last few months. The horse is by no means one of the most intelligent of animals, and his usual tricks do not assume a higher form than that of waltzing on

his hind legs or caracolling at the bidding of his masters. There have, however, been one or two "calculating horses" who were able to tap out numbers with the fore-leg, but they have generally been noticed to keep a pretty sharp eye on the movements of the trainer, who probably possessed some means of indicating to them the requisite number of taps. But the performances of Hans have been so extraordinary that he has been submitted to an examination before a commission of thirteen experts, including Dr. Nagel, Professor of Physiology in Berlin, and Professor Stumpf, Director of the Psychological Institute. This commission has unanimously decided that Hans solves problems and answers questions as the result of a mental process analogous to that of the human brain, and that he is not influenced in any way by the acts or suggestions of his owner. If this really be true it is to be hoped that a full, signed account of the examination will be issued, for Hans will certainly deserve to rank with one of the seven wonders of the world. It is well to bear in mind the circumstantial reports showing that Hans acts under the influence of a wire-pulling attendant, and that the whole thing is a trick of the "spiritualist" order.

#### The Sequence of Disease Phenomena.

THE apparent want of regularity often noticeable in the processes of Nature is sometimes difficult to reconcile with the existence of definite laws. The principle of conformity to type is, however, so frequently departed from that the existence of biological "sports" is fully recognised. The manifestations of disease itself, though generally following the classical descriptions set forth in text-books, yet at other times differ so widely from the standard that a difficulty is felt in placing them under any known pathological group. Many a time the practitioner is confronted with an affection of which he may truly say, "I have never seen this described in the books!" The modes of onset and the clinical appearances of disease vary not less than the countenances of the patients. It is doubtful whether two cases of typhoid fever, for instance, are precisely identical in every particular, as regards either onset or course. Abortive forms, to which the terms "ambulatory" and "larval" are sometimes applied, are comparatively common. Certain affections adhere more or less strictly to a definite order in the appearance of their symptoms, as, for example, acute lobar pneumonia. Others, especially those of a functional character like hysteria, are a law unto themselves. A correct diagnosis is, no doubt, greatly facilitated when the disease conforms to a well-known type, but the sequence of morbid phenomena is often much disturbed, particularly in children. Dr. Adolph Rupp<sup>(a)</sup> has reported a most instructive case of measles in a young child, in which all the ordinary symptoms and signs of that complaint were reversed, the illness commencing with diarrhoea and bronchitis. The next day penumonic

consolidation was discovered, and the day afterwards the typical morbilliform rash made its appearance.

#### The Garden City.

PERHAPS the most practical piece of philanthropy of late years has been Mr. Booth's Garden City scheme, for it supplies what most philanthropic undertakings unfortunately lack—a sound commercial basis. The idea of a garden city, an open-air town, where every prospect pleases and man is made as little vile as possible, was a bold one, and was regarded as Utopian when it was first mooted. But the Garden City Company have to-day reached a point at which the success of their first city is assured, and the future holds many possible extensions of their scheme. The situation of this first city is an admirable one, standing three hundred feet above the sea level near Hitchin, and already the plan of the town is being mapped out and the sites are being taken up. Beauty and hygiene are the two factors that govern all the designs, and for the first time in history it seems as if beauty and hygiene are going to pay a dividend. Manufacturers are being attracted in numbers by the cheapness of land to transfer their works there, and already sufficient have been actually arranged for to give employment to twelve hundred families. The Garden City is thus assured of some five thousand inhabitants, a sixth of the number that the Company have fixed as the limit of the population. A beautiful stretch of country is being converted into a public park, whilst besides the model cottages that are being erected, a number of wealthy people are arranging for country houses on the outskirts of the town. The extraordinary feature of the project is the cheapness of everything, for land is to be obtained at a ground-rent of £10 per acre, and rates are to be fixed at 15 per cent. No wonder that the Londoner's mouth is being made to water at the prospect. We hope that the Garden City will achieve the success it so warmly deserves, but it is not likely to solve all the hygienic problems that beset it unless its plans and designs are submitted to careful medical supervision.

#### Incubation Period of Typhoid Fever.

AN experiment of great interest and importance was performed on a human being in Paris. Fortunately the anti-vivisectors cannot blame the doctors this time, for the seat of the experiment was the *corpus vile* of the experimenter. A nurse, wishing to put an end to herself, swallowed two tablespoonfuls of broth-culture of Eberth's bacillus, but, to her chagrin, no untoward effects followed at the time. On the third day, however, she was unwell with headache, though she had no fever, and by the sixth day she was obliged to take to bed with feelings of malaise and weakness in the lower limbs. The temperature the next evening was 38.6° C., and the following day she had epistaxis, several rose-spots, and pyrexia to the extent of 40.2° C. On the tenth day Widal's reaction was present. The attack

(a) *Amer. Journ. of Obstetrics*, August, 1904.

ran the ordinary course of typhoid fever of great severity, as may be gathered from the fact that not less than 176 baths were given. Now, although deliberate experiments on human beings are so monstrous as to be quite out of the question in any community, there is no gainsaying the fact that when they happen to be performed as in this case they afford information of the highest utility. This incident to the Paris nurse shows not only that Eberth's bacillus is the specific causative organism of typhoid fever, if any further confirmation were needed, but it throws fresh and unexpected light on the incubation period of the disease. Mr. Duflocq Voisin, who reports the case, attributes the shortness of this period—only two days—to the large number of bacilli ingested, but be that the case or not, we must now be prepared to admit that the minimum incubation time of typhoid fever may be very short indeed. We know that the bacilli in some cases take as long as three weeks to produce their effects, and that the usual period is about ten days or a fortnight, but it is now established beyond doubt that it is possible for them to set up typhoid fever in forty-eight hours.

#### Post-Diphtheritic Adiposity.

DIPHTHERIA is a disease that has many far-reaching results, and it is well known that convalescents from acute diseases often rapidly make up the loss of tissue they have sustained during their illness. But we venture to think that Miss Elizabeth Daltrey, æt. 9, of Bethnal Green, enjoys a unique distinction in being in possession of 10 stone 3 pounds of body-weight as the result of an attack of diphtheria. Apparently a normal child till overtaken with the disease, no sooner had it run its course than she began to put on flesh, or rather fat, at an alarming rate. Her waist now measures 42 inches, her chest 46 inches, and her arm 16½ inches—not a mean record for a child 4 feet 6½ inches high. The clue to her abnormal development seems to lie in her appetite, which is reported to be prodigious. She consumes as a rule twenty-four slices of bread and butter, besides beef, potatoes, and other necessities of life, every day. Of course this wretched little monstrosity is being exhibited by music hall proprietors to excite the wonder and admiration of their clients; it is too much to expect parents and impresarios to refrain from filling their pockets at the expense of public decorum. Instead of this child being placed under medical care and supervision she is being paraded nightly to excite the gapes of East End audiences—a state of things we should have thought that would hardly have been permitted by the magistrate who has to sanction her performance. Children of the proportions of Elizabeth Daltrey are the subjects of disease, and only a morbid pleasure can be derived from watching their clumsy antics.

#### Insanity in India.

IN the Annual Report of the Lunatic Asylums of Bengal recently issued, Colonel Browne gives us many particulars which are of interest by way

of comparison and contrast with the statistics of insanity in these countries. Just as at home, the asylum population is increasing year by year, and the figure reached last year in Bengal—1,348—is the highest yet recorded. Colonel Browne does not regard this increase as signifying an increase in the actual number of lunatics in the province, but rather as due to the more frequent resort to asylum treatment. If this view is correct, and it is borne out by the Census figures of 1901, which show a decrease in the total number of lunatics, then the increase in the asylum population is rather a matter for congratulation than otherwise. The principal cause of mortality was tuberculosis, and the death-rate was 100 per thousand—the highest in Indian asylums, the lowest being 76 per thousand in the Punjab. At Decca, where tuberculosis was most rife, there was considerable overcrowding, only fifty superficial feet of space being available for each patient. As in most asylums, mania is the most common type of insanity met with, but during the year no case of general paralysis of the insane was noted. It is by no means common in any Oriental race—a fact worth remembering in relation to the discussion as to its dependence on syphilis.

#### Diseases of Country Women.

AN interesting investigation has recently been conducted by an organisation in Canada known as the National Council of Women. Circulars were distributed to a large number of farmers' wives and daughters throughout Ontario containing queries as to the state of health prevailing in that class. A poll has thus been taken of the commoner diseases, and the two diseases which are said to have pre-eminence are rheumatism and "catarrh." The term rheumatism is probably used in a very wide sense, including all the chronic affections to which the name is given, most of which are due to the exposure to cold and wet to which these women are liable. In addition, the site of the farmer's house is often unsuitable, being damp and undrained. Associated with rheumatism mention is made of purpura, erythema nodosum and urticaria. "Catarrh" in Canada is applied in a somewhat narrower and more specific sense than in this country. It means usually a chronic pharyngitis, beginning very gradually, but often going on to an extensive thickening of the mucous membrane of the pharynx, spreading to the larynx, the nares, and not infrequently the Eustachian tubes. A common enough result is a troublesome deafness. The cause of the condition is obscure, but it is generally said to be the constant breathing of impure air in ill-ventilated rooms. This theory is supported by the fact that it is much rarer among the men than among the women on the farms, as the former spend much of their time out of doors. Among the diseases which appear with lesser frequency are dyspepsia and anæmia, while one sufferer returns her trouble as "that tired feeling." It is a pleasure to find consumption is not prominently mentioned.

### The Suckling of Infants.

THERE is no doubt that the practice of rearing children by hand is in many cases a result of the same distaste for parental responsibility of which we have heard so much in regard to the artificial prevention of conception. In the higher ranks of society it has always been unusual for the mother to suckle the child, but there is grave reason to believe that a similar reluctance is spreading throughout all ranks. A good deal of discussion on the subject has taken place in France recently, and the well-known charity of the "Gouttes de Lait" has been accused of encouraging the habit. Our readers will remember that this charity was established a few years ago to supply working women with suitable artificial milk for their children. It is now maintained that the comparative excellence of the supply encourages nursing women to wean their babies and feed them otherwise than from the breast. The consequence is that where a branch of the "Gouttes de Lait" has been established nursing is less and less practised by mothers. It is doubtless true, however, as is pointed out on the other side, that the conditions of modern life tend to make it more impossible for working women to give as much of their time to their infants as formerly. The post office, the telephone, the typewriting machine, not to speak of the factory, keep women tied to long hours of labour which render the nursing of an infant either an impossibility or such a drag as to prove a serious business embarrassment. In such cases, and in others where healthy mother's milk is unavailable, there is no doubt that the "Gouttes de Lait" is doing excellent work. At the same time the greatest care is necessary in its administration, and it is always to be remembered that the substitution of artificial for natural feeding is never to be made without the gravest consideration.

### Rubber Gloves.

IT has become so much the fashion to wear gloves while operating that there are doubtless many who merely follow the fashion without paying much attention to its underlying basis of reason. In doing so they are very liable to render their trouble futile by overlooking some simple precautions. The principal, though not the only reason for wearing gloves is that they, unlike the hands, can be rendered absolutely sterile. Nevertheless one often sees a surgeon, when preparing for an operation, wash his hands with a certain amount of care, probably less than he would take if he were not about to wear gloves, and then proceed to put on the sterilised gloves, using his hands freely in doing so. If his hands were sterilised by the washing, why proceed to wear gloves? If they were not sterilised, then the gloves have been thoroughly exposed to infection in the process of drawing them on. Or, again, if the gloves are floated in water or antiseptic solution, then a certain amount of fluid is bound to be left in the fingers. The skin soaks in this for a little, infects it, and a change of level discharges the fluid into the wound. It

is curious how often points such as these are overlooked even by careful surgeons, unless their attention is specially drawn to them. Dr. Howard Collins, of New York, who has given a good deal of care to the subject, (a) is convinced that gloves should always be worn dry, using sterilised starch or lycopodium as a lubricant. In drawing on the gloves nothing should be used except a couple of pairs of dressing forceps, and a little practice renders this easy.

### The Position of Gynæcology at the Meetings of the B.M.A.

OUR readers may remember that we drew attention to, and strongly criticised, the arrangements at the recent meetings of the British Medical Association, by which papers dealing with obstetrical and gynæcological subjects were brought before sections other than that devoted to the consideration of such subjects. We are glad to learn that the Council of the Association has adopted views similar to those which we expressed, and that it has decided that, in future, the allocation of papers to their respective Sections shall be subject to its directions. This decision means that gentlemen who desire to display their knowledge of special subjects must do so before the Sections devoted to those subjects, and not before some other Section which they may personally favour. To discuss the subject of hysterectomy before the Surgical Section of the meeting when a Gynæcological Section was in existence was about as suitable an arrangement as it would have been to have discussed the treatment of middle ear disease before the Medical Section. We can quite understand the desire of a general surgeon to gather every branch of special surgery into the Surgical Section, but we cannot understand the Association permitting such a course, unless it at the same time decided to abolish the Special Sections.

### The Children's Tooth-Brush.

THE need of systematic attention to the teeth, especially during childhood, is not by any means universally recognised. So it would appear, at least, from the deliberations of a certain rural board of guardians. The suggestion of one of their number that the children in their cottage home should be supplied with tooth-brushes was not only thrown out by the majority, but the proposal was actually ridiculed by a select few, among whom was the Mayor of a well-known watering-place, who considered that such luxuries would lead to greater degeneration of the race than that already existing. Hard crusts are all very well in their place, but what if the teeth are too decayed to bite them? The toast, made by others, that they themselves had never used such an essential article of toilet, nor their fathers before them, and yet had attained to a good old age, is unworthy of an assemblage of civilised folk. We wonder what the medical member of the board (if there were one) said at the

(a) *Medical News*, N. Y., August 20th, 1903.



discussion. Could those who look at the tooth-brush with contempt simply because they themselves happen to be blessed with a naturally perfect set of grinders pay a visit to the Dental Hospital and see for themselves the deplorable state of many people's teeth as a result of neglect, they would doubtless reconsider their decision. One need not go so far. Take the teeth, for example, of any number of school-children, presumably healthy, and the large proportion of those with imperfect dentition in which caries chiefly predominates will surprise those who have not previously paid any attention to the subject. The statistics of the medical officers to the School Board bear out this fact over and over again. Bad teeth and the accompanying oral sepsis contribute much to the physical degeneration. As a set-off, however, to such short-sighted policy, it is gratifying to note that another board of guardians has recently appointed a qualified dentist to look after the teeth of the children in their homes.

#### Pregnancy in Uterus Bicornis.

VARIOUS good authorities have stated that pregnancy does not occur in a bicornate uterus, but the dictum is shown by recent records to belong to the class of generalisations condemned by Bacon: "*Inductio per enumerationem simplicem ubi non experitur instantia contradictoria.*" Contradictory instances have, however, been found, and so the supposed law fails, but at the same time the recorded instances are so rare that they deserve notice when they occur. One of the best authenticated is a case recently published by Dr. Green of Boston. (a) During labour the uterus was seen to be divided into two distinct parts by a median sulcus, which became deepest at the fundus, and was accentuated by each contraction. On the right side the foetus was made out, while on the left a placental bruit was heard. After the birth of the child, a mass of the size of a normal uterus in the third stage remained toward the left, while a smaller one was felt to the right. Exploration of the uterus after the puerperium bore out the diagnosis. The sound only passed a short distance in the middle line, but slipped to one side or other. The cornu on the right side was five inches in depth, that on the left half an inch more.

#### The Brutality of Kindness.

To the outsider many of the professional acts of the medical man must savour of downright hard-hearted brutality. But it is kindness in reality akin to that of the parent who refuses to spoil the child by sparing the rod. The keen knife and the manipulations of the surgeon save many a limb and many a life. Were it not for the iron nerve of the trained men of medicine, both physicians and surgeons, the mortality of poor, maimed and suffering humanity would rise straightway to

the fever pitch of pre-scientific days. The refusal to recognise the necessity of subordinating the lower animals to the ultimate good of man in the experimental laboratory has led to the strange, sad, erratic, and contradictory cult of the antivivisectionist. Fanatics of that order eat boiled lobsters, blanched veal, driven grouse, grilled cod and salmon; decorate their hats with egret's feathers and stuffed humming-birds or gulls; flog their horses and put them in bearing reins; shoot trapped pigeons, hunt tame deer, and commit many acts of wanton cruelty that would make the average thinking medical man shudder to contemplate. Yet they, sooner or later, become the patients of the men they so bitterly denounce. A fortnight ago an amusing instance of misplaced indignation was divulged at an East London inquest. Some maternity students from the London Hospital were accused of behaving with great cruelty to a baby. It appears that they were really trying to animate a gasping new-born babe by the Schulz system of respiration, which involves swinging the child about in the air. The jury found that death was due to insufficient expansion of the lungs, and the students accordingly returned to their scientific labours, to use the language of the police-court reporters, "without a stain upon their characters."

#### Reversed Peristalsis of Intestines.

THE question of reversed peristalsis in the alimentary canal is both interesting and also of considerable practical importance. Partial peristalsis is seen in the curious power of regurgitation of food from the stomach to the mouth possessed by some persons, a faculty more or less closely analogous with the herbivorous habit of "chewing the cud." Peristalsis is also concerned commonly in bilious vomiting. Another familiar example is faecal vomiting in the later stages of intestinal obstruction. Reversed peristaltic action of the whole alimentary canal, however, is extremely rare. A most interesting instance recently occurred in a patient at the Westminster Hospital under the care of Dr. William Murrell for ulcerative colitis. The malady was cured by the injection into the bowel of argyrol, a chemical combination of synthetic vitellin containing 30 per cent. of silver. When about five pints of solution had been injected, the patient being in the knee and elbow position, fluid was seen pouring from his mouth. The same sort of thing happened at subsequent injections, and it was proved by chemical tests of the vomited fluid that the unaltered silver had passed through the whole length of the canal from the rectum to mouth. For some reason or other the ileo-cæcal valve had failed to exert its usual action against backward pressure from the colon side. The case is of value, as it is an accurate and scientific record of a rare clinical occurrence.

#### An Extraordinary Action for Malpraxis.

A REMARKABLE action for damages is pending in the French Courts, the defendant being a well-known surgeon, Dr. J. B. Fort. We gather that

(a) *Boston Med. and Surg. Journ.*, June 9, 1904.

Dr. Fort undertakes to bring about dilatation of pyloric obstruction by electrolysis, apparently on the lines followed some years since in the treatment of urethral stricture. He makes use of an insulated electrode, with a flexible gum-elastic end as a guide. This he introduces through the œsophagus, and in so doing, in this particular instance, the "guide" broke off. As there was no reason to anticipate any trouble from the passage of this pliable foreign body through the intestines matters were allowed to take their course, but a few days later the patient was seized with violent abdominal pain and promptly succumbed. Nothing more was heard of the matter for some months, when a discharged assistant of Dr. Fort's wrote to the widow informing her that her deceased husband had been the victim of a surgical mishap, whereupon the widow instituted proceedings to recover damages. The body was exhumed, and was carefully examined by several experts in the presence of the defendant. The terminal portion of the sound was discovered in the intestine, not apparently having caused any local injury. If this version be correct it is difficult to see what ground for action there can be, and it seems highly probable that the proceedings will end in a non-suit.

#### No Public Mortuary.

It is a lamentable fact that many districts, some of them densely populated, both in town and country, are unprovided with a public mortuary. The way out of the difficulty has been hitherto met in the time-honoured way by taking off the body of anyone found dead to the nearest public-house. But even the "trade" may revolt and turn away from its doors the passive harbinger of "crowner quests." Such was the case at Maidenhead the other day when a body was found in the river. After being refused by several publicans, the body was deposited on an island for several hours among the rushes, but room for it was eventually found in an unoccupied public-house belonging to the Corporation. Can it be believed that Maidenhead, the wealthy, the populous, the picturesque river resort, is without a public mortuary? Such, however, is the fact. It would be as well to insert a clause in the next Public Health Act making it compulsory on all local sanitary authorities to provide adequate mortuary accommodation in their districts.

#### The Origin of Elements

SIR WILLIAM RAMSEY is not the man to boast or speak prematurely, and an announcement he made at a dinner given to him by the Society of Chemists in New York cannot but stir the curiosity and interest of the whole scientific world. Sir William stated that he believed chemistry to be on the eve of discovering the origin of elements—a conclusion he had come to as the result of his own researches and experiments. He has recently discovered a new substance of such properties as to place the whole question in a new light, and he hopes to

publish his work shortly to the world. It is tantalising to be told so much and yet have to wait some months before being admitted to the whole secret, but one may safely trust the discoverer of argon and helium not to buoy his admirers up with false hopes. The science of chemistry has moved with rapid steps of late years, and the wonders of radium seem likely to lead to conceptions of the origin of matter that would have been regarded as rank heresy ten years ago.

#### PERSONAL.

H.R.H. THE DUCHESS OF ALBANY will open the new operating theatre at the National Hospital for the Paralysed and Epileptic, Queen Square, London, on October 8th.

DR. W. A. BURT has been elected President of the Ontario Medical Association for the coming year.

MRS. BARROW has endowed a bed in the Liverpool Royal Infirmary at a cost of £1,000, in memory of her late husband, Mr. William James Barrow.

DR. SCHWENINGER, who was at Friedrichsruh in attendance on the late Prince Herbert Bismarck, was for many years the physician of the Iron Chancellor.

PROFESSOR KOCHER, of Berne, will preside over the first congress of the Société Internationale de Chirurgie to be held in Brussels in September, 1905.

ON behalf of the David Lewis Trust, Mr. B. W. Levy formally handed over to the Lord Mayor of Manchester, as representative trustee, the title-deeds of the Saalbridge Colony for Epileptics.

SURGEON-MAJOR T. E. F. MCGEAGH has resigned his commission in the Honourable Artillery Company of London, and retires into the Veteran Company, with permission to wear the uniform of the corps.

SIR WILLIAM MCGREGOR, who recently kissed hands at Balmoral on his appointment as Governor of our oldest colony, Newfoundland, just thirty years ago took his M.D. degree at the neighbouring University of Aberdeen.

THE appointment of Dr. Herbert M. Ellis, Inspector-General of Hospitals and Fleets, to the position of Director-General of the Medical Department of the Navy, in the place of Sir Henry F. Norbury, whose term of office has expired, is now officially announced.

DR. LORRAIN SMITH, formerly Professor of Pathology in Queen's College, Belfast, who has been appointed Professor of Pathology and Pathological Anatomy in succession to Professor Delépine, in the University of Manchester, will open the Medical Session at the latter on Monday, October 8th, by delivering an inaugural address.

SISTER MARGARET BROWN, the English hospital nurse nursing the Queen of Italy, was specially selected for the post by the Matron of Queen Charlotte's Hospital, where she was for some time a sister. Needless to say, in addition to her high professional qualifications, she possesses tact and all the other qualities which are essential in a good nurse.

PROFESSOR MORISANI, the Queen's accoucheur, is a well-known person in Italy, for one reason, on account of his exceedingly dwarf-like stature. The Professor, who lives at Naples, has a son in the same profession as himself, and almost of the same size.

## Special Correspondence.

[FROM OUR SPECIAL CORRESPONDENT.]

## SCOTLAND.

**EDINBURGH UNIVERSITY AND DEGREES IN VETERINARY MEDICINE.**—It is a matter of public knowledge that for some considerable period negotiations have been going on between the Town Council, as trustees of the Royal (Dick) Veterinary College, and the University authorities in reference to the question of the granting of degrees in veterinary science. The position of matters now, as explained in an evidently authoritative article in the *Scotsman*, seems to be somewhat as follows:—The Dick College, founded in 1823, is apparently the only endowed institution of this nature in the country. It was affiliated to the Royal College of Veterinary Surgeons of London on their incorporation in 1844, and, since the death of its founder in 1866, has been under the guardianship of the Town Council of Edinburgh, by whom it was remodelled in 1886, so that now the whole tuition required is given in one compact, centralised building. The curriculum, formerly a two years' one, now extends over four winter sessions of thirty weeks, leaving the summer free for practical work in the country. Each group of subjects has to be "passed" in before further attendances qualify for subsequent examination—a provision which many of us would have the medical curriculum imitate. Students failing for more than a year without reasonable cause are permanently disqualified. Not very long ago the prospect of a largely increased endowment of veterinary science appeared. Mr. McAllum, a veterinary surgeon in Edinburgh, offered £15,000 to endow a chair of pathology and bacteriology; Miss Dick, the sister of the founder, has bequeathed about £23,000, part of which is for a chair of comparative anatomy; and further moneys are expected to fall in. Further, the New Veterinary College, which hived off from the Dick, has been absorbed into the new school at Liverpool, and no longer needs to be considered in any amalgamation scheme. The projected scheme of the Town Council and University contemplates a new Conjoint Administrative Board, and the removal of the college from the guardianship of the Council, a body obviously unfitted to manage such an institution. The University has issued a draft ordinance somewhat on the lines of graduation in medicine, with Bachelor's and Doctor's degree in veterinary science. The preliminary examination is to be the same as for medicine, *i.e.*, a higher standard than the existing one, and the course covers the subjects required by the College of Veterinary Surgeons *plus* heredity and the general principles of breeding. Before graduation, the candidate must be registered as a veterinary surgeon. One of the special difficulties is that veterinary registration is under a one-portal system, and two sets of examination fees will require to be paid, and two examinations passed unless some arrangement can be come to whereby the College examinations are, in the case of University candidates, accessible to university examiners.

**MATERNITY WORK IN EDINBURGH.**—The Milne Murray Lodge, which is now open for the reception of students, will greatly enhance the possibilities of getting a sound practical training in obstetrics in Edinburgh. The Lodge is close to the Maternity Hospital, and is in telephonic communication with it. Twelve students are accommodated at one time, and the usual period of residence is a month, each during that time easily overtakes his six cases. As a matter of fact, we believe that, besides these extern cases, the men during the past month had the opportunity of seeing nearly forty confinements, most of them abnormal, a great advance on anything practicable hitherto.

JOHN DALE TUCKER, stated to be an M.D. of Pennsylvania, U.S., was fined £10 and £5 costs on each of two informations before the Liverpool magistrates on Saturday for affixing the name of Dr. John Gould to two death certificates.

## Correspondence.

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

## THE DIMINISHING BIRTH-RATE.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*

SIR,—The discussion on this important subject has been up to the present somewhat disappointing. As a layman, after carefully following up the original articles and the subsequent letters, it seems to me that Dr. Walsh pointed out a serious flaw in Dr. Taylor's paper in the omission of illegitimacy figures from the total birth-rate. Then "LL.D." exposed an error in Dr. Walsh's figures, in answer to which the latter says the mistake does not affect his main arguments. Several concrete examples have been brought forward by correspondents asking Dr. Taylor whether his universal law of unrestricted families applies to their particular cases. The answer they have obtained can hardly be called satisfactory, and it certainly seems to me that Dr. Walsh's main criticisms have yet to be answered. The matter stands here for the moment. I sincerely trust more light will be forthcoming from the medical profession before it is allowed to drop. Why should good, struggling, sensible, kindly citizens be asked to bring up children with no prospects better than those of the streets and the workhouse? What is the value of abstract and ill-supported ethical theories to them?

I am, Sir, yours truly,

L. W. HUDSON.

Herne Hill, S.E.

## THE LUNACY QUESTION.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*

SIR,—I have no desire to discuss this question beyond Dr. Robert Lee's point as to our incapacity in defining insanity. The apparent difficulty in arriving at an acceptable definition consists in the fact that such diverse views are held as to what constitutes insanity, and so long as this exists it is obvious no unanimity or concurrence of opinion can exist. For example, a case was recorded a few days ago at an inquest on the body of a drowned sailor. It transpired that a delusion, common among sailors, had existed in the mind of deceased, that learning the art of swimming created an unfavourable omen as to fatality in drowning—a delusion not altogether harmless. Now, theoretically, one person might regard this as evidence of insanity, and another the reverse. Certainly, neither could define it as *legally* insane. Further as medical men, we are only called upon to certify insanity for legal purposes, and with this idea I ventured to define it in your columns recently "as a morbid condition of mind requiring supervision." Dr. Lee will observe that I do not commit myself by saying even legal supervision, which would necessarily at once subject a person to the hands of the law, whereas on the other hand, if we suppose, say, the validity of a will on the ground of imbecility or otherwise were questioned in a law court, the issue, as far as I conceive, would be determined on the definition in question one way or the other. Dr. Lee, who also observes that we are not required to define insanity as applied to any given individual in a lunacy certificate, which I so far agree is impracticable, because we do not understand mind sufficiently as he rightly suggests. We are only asked to *describe* the case in the lunacy form, and not to define insanity therein. Granted the apparent difficulty in agreeing to a definition as to what constitutes insanity, surely all specialists are in accord on one point, and that is in regard to the insane requiring the interposition of the law, and it is upon this idea I submit they must found their definition.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, September 8th, 1904.

### Obituary.

#### MR. ISAAC HARTHAN, M.R.C.S.ENG.

We regret to announce the death of Mr. Isaac Harthan, surgeon, who died at his residence, Blythewood, Parkfield Road, Didsbury, on the 5th inst. He retired from practice some years ago. Formerly for a long period he followed his profession in Hulme, and lived in City Road. Mr. Harthan became a member of the Royal College of Surgeons in 1856 after studying at Liverpool.

#### HENRY ARTHUR BENHAM, M.D., OF BRISTOL.

We regret to announce the death of Dr. Harry Arthur Benham, the medical superintendent of the asylum at Stapleton, at that institution on the 14th inst. He had been in indifferent health for some months past and, therefore, although his death was sudden, it was not entirely unexpected. The cause is stated to be heart failure. The deceased succeeded Dr. George Thompson on that gentleman's retirement in 1890 from the asylum, and with which he had been connected as assistant medical officer for some eight or ten years, and he had therefore put in over twenty years' service there. He was in his fiftieth year. A strong Conservative, he took a keen interest in politics, but was precluded from taking any active part in them owing to his position. He was an enthusiastic Freemason, and had held several prominent offices in the Order. He took his M.D. at Aberdeen in 1883. He was a lecturer on mental diseases at the University College, Bristol, and a member of the Council of the Medico-Psychological Association of Great Britain and Ireland. From time to time he made valuable contributions to the medical papers on his special subject. His father came of an old Bristol family. His only brother was also a medical man, but he died some years ago while abroad. He will be mourned by a large circle of friends, and especially amongst his professional and Freemasonry brethren.

#### CHARLES WILLIAM IZOD, M.D.

The death took place last Friday, at Whitehall Court, Westminster, of Dr. Charles William Izod, who for many years was medical adviser to the members of the French Royal Family during their residence at Claremont Palace, Esher, and latterly to the Duchess of Albany. He was also present at the death of Queen Amelie and the Duchesse de Nemours. Dr. Izod, who practised for fifty years in Esher, was, on the occasion of his jubilee, presented with a testimonial by the Duchess of Albany. His qualifications were M.R.C.S. Eng., taken in 1846; L.S.A., 1847; and L.M.Dub.

#### EDMUND CARVER, M.D.

DR. EDMUND CARVER, formerly demonstrator of anatomy at Cambridge University Medical School, but who had retired from practice, died on Wednesday at Torquay at the age of eighty. Dr. Carver was admitted a Member of the Royal College of Surgeons, England, in 1848, and a Licentiate of the Society of Apothecaries the following year, having professionally studied at University College Hospital Medical School. In 1854 he was elected a Fellow (by examination) of the Royal College of Surgeons, in 1858 graduated B.A. from St. John's College, Cambridge, in 1859 took the M.B. degree, and in 1866 proceeded M.A., but only took his M.D. in 1891. Besides being Demonstrator of Anatomy at Cambridge, he was Surgeon and afterwards Consulting Surgeon to Addenbrooke's Hospital, was a Fellow of the Cambridge Philosophical Society, at one time a President of the Cambridge Medical Society, and was a retired Surgeon-Major of the Cambridge University Rifle Volunteers. Dr. Carver had also been House Surgeon to University College Hospital, Gower Street, Resident Clinical Assistant at the Consumption Hospital, Brompton, and Surgeon to the Huntingdon County Hospital and the Hunts Rifle Regiment Militia.

#### FLEET-SURGEON JOSEPH WOOD, R.N., M.D.

THE death took place at Glengall, Hurstpierpoint, on the 5th inst., of Fleet-Surgeon Joseph Wood, R.N. (retired), at the age of 62. Mr. Wood, who took the degree of M.D. of Edinburgh in 1864 and L.R.C.S. Edin. and L.M. in 1866, joined the service in 1869, became staff-surgeon in 1880, and fleet-surgeon ten years later, retiring in 1893. He was surgeon of the *Himalays* during the war against the Zulus from 1877 to 1879 and was awarded the Zulu medal.

#### SURGEON-GENERAL JAMES JAMESON, C.B.

SURGEON-GENERAL JAMES JAMESON, C.B., died on Tuesday last at his residence, Newlands, Eltham. The son of Mr. William Jameson, of Ladeside, Kilbirnie, N.B., he was born in 1837, and was therefore 67 years of age. He became an M.D. of Glasgow University in 1865, and, having entered the Army Medical Service as Assistant Surgeon in November, 1857, he became Surgeon in March and Surgeon-Major in April, 1877. Surgeon-Colonel in 1888, and Surgeon Major-General in 1893. In May, 1896, he was promoted to be Director-General of the Army Medical Service, which appointment he held till 1901. Surgeon-General Jameson was made a C.B. in 1897, was honorary surgeon to the King, and a Knight of Grace of the Order of St. John of Jerusalem. During the Franco-German war of 1870-71 he served with the English ambulance. He married, in 1864, a daughter of the Rev. Robert David Cartwright, of Kingston, Canada.

#### COLONEL JOHN HENRY BEATH, M.D., C.B.

THE death was recently announced at Stirling of Lieutenant-Colonel John Henry Beath, M.D., C.B., in his seventieth year. He was a son of the late Dr. Andrew Beath, of Stirling, and was educated at the High School of that town. Later he graduated M.D. of Edinburgh University. He received in 1857 an appointment on the Medical Staff and served on it during the Indian Mutiny, being present at the siege and capture of Lucknow. In 1859 he joined the 3rd Foot (The Buffs), and was with his regiment in the China war of 1860. Colonel Beath's foreign service extended over fourteen years, his last campaign being the Egyptian expedition in 1882, when he was mentioned in one of the despatches of Sir Garnet Wolseley in the following terms:—"Surgeon-Major J. H. Beath, M.D., has been brought to my notice for some special favour, and I am glad to have this opportunity of recommending so zealous and hard-working an officer." Queen Victoria accordingly conferred upon Dr. Beath the Order of the Bath, and gave him permission to accept and wear the insignia of the Order of the Medjidieh, which the Khedive had conferred upon him. For ten years he held the garrison appointment in his native town of Stirling, from which appointment, owing to failing health, he retired only two years ago.

### Literature.

#### PRYOR ON GYNÆCOLOGY. (a)

AFTER reading the title-page of this work expectations were raised which were subsequently destined to be agreeably disappointed. We looked forward with no undue degree of pleasure to reading one of the latest additions to gynæcological text-books—innumerable as these seem to be in America. Yet, Dr. Pryor's reputation as a distinctly original worker in the field of operative gynæcology is by no means confined to his own land, and we were somewhat surprised that he should have added another to the student's already crowded choice in the matter of text-books.

(a) "Gynæcology": a Text-Book for Students, and a Guide for Practitioners. By W. E. Pryor, M.D., Professor of Gynæcology, New York Polytechnic Medical School, &c. London and New York: D. Appleton and Co., 1903.

But the title is the only part of this suggestive work which we could willingly dispense with. It is somewhat of a misdirection, for Dr. Pryor has given us a valuable addition to gynecological literature which is, however, from the student's or examination point of view a very poor text-book. But the book has a more abiding interest than any mere examination guide; it is a personal document which deals, if briefly, always suggestively, with some of the chief problems of modern or surgical gynecology.

This point of view being kept in mind, we can understand the omission, noted in the preface, of such subjects as bacteriology and pathological histology—subjects which, however, we could nowise accept as properly excluded from the pages of a work intended primarily as a student's text-book, or even for the guidance of the average practitioner. In our mind it is certainly debatable whether the gist of Dr. Pryor's message, which is essentially one to specialists—might not have been better conveyed in the form of a book of essays on technique in modern gynecological work. In any case it is true to say that this book—or much of it—will prove useful and interesting exactly in proportion to the previous personal knowledge and experience of the reader. We are convinced that the proper reader will turn again and again to its pages, not necessarily for agreement, but for views which are founded on a large and well-studied experience, and which are always clearly and suggestively stated. It is only needful to add that the illustrations and general get-up of the book are admirable.

#### SODDY ON RADIO-ACTIVITY. (a)

As the author observes in his preface: "The discovery of this new property of self-radiance, or 'radio-activity,' has proved to be the beginning of a new science, in the development of which physics and chemistry have worked together in harmony." The pioneer in the chemical development of the subject was, as is, of course, well known to all readers, Madame Curie, and our author places prominently before us the less universally familiar fact that "On the physical side, the brilliant and elaborate researches of Prof. Rutherford, at first mainly with thorium—an element which, like uranium, is so feebly active that it had been studied for a century before its radio-activity was discovered—paved the way for a complete and general theory of the cause and nature of the new property." The fundamental basis of this theory is that the *radio-active* elements are in a process of evolution (or devolution) towards lighter and more stable forms; that they are proceeding in this direction by a line of continuous and explosive disintegration of the constituent atoms; and that the fragments thus set free are spontaneously ejected in directly eccentric courses, and thus constitute the characteristic "radiations." The recent discovery of the continuous production of elementary helium from radium is, of course, a direct experimental confirmation of this theory.

The study of the subject of radio-activity has opened up new and unexpected views of the constitution of matter. It has "burst up" physically and metaphorically the previously indivisible "atom." As we ourselves could never picture to our unscientific fancy such an entity as a finally indivisible atom, we cannot pretend to lament its scientific extinction. And, as the Daltonic atom was but a chemical adaptation of the ideas of Democritus on the constitution of matter, so the discoveries of M. Becquerel and Madame Curie carry us back in imagination to the conceptions of Thales, when the first of Greece's famous roll of wise men taught his disciples that all forms of matter were ultimately reducible to a single element. Although the physico-chemical "Volapuk" of the present genera-

tion may not agree to recognise a single and universal basis of matter—whether under the name of *helium* or *hydro*, or *moisture*—the fact is unquestionable that the general trend of recent physical and chemical discovery has been to make scientists suspect, if not actually believe, its essential unity.

Of course, the great practical interest which the new science of radio-activity possesses for medical men is its promise in the broad domain of therapeutics—especially in the section devoted to the treatment of the hitherto hopelessly intractable forms of carcinoma, sarcoma, and tuberculous disease. In this connection, and on this account, we heartily welcome Mr. Soddy's work, as an excellent introduction to the study of the subject. And as no science is really foreign to medicine—not even the so-called science of metaphysics—we strongly recommend this volume to the attention of our readers. The intense interest attached to scientific research and discovery is—surely should be—the silvery margin of the too frequently clouded aspect of a medical career; and, although the consciousness of the possession of knowledge hourly approximating to that of the angels may offer but cold consolation to a dispensary doctor during his hill-side pilgrimage of twelve or fifteen miles in a blinding and petrifying blizzard, it will surely give him in his house of rest that soothing conscientiousness of the high-minded performance of the noblest duties allotted to humanity—those in which man approaches most closely to the thoughts and actions of the "Divine Exemplar" Himself.

#### KIRKBY'S PRACTICAL PRESCRIBING. (a)

PRACTICAL pharmacy is in danger of becoming a lost art. Most modern medical practitioners would seem to have but little genius for dispensing, and with the present vogue for factory-made medicines medical students have but little inducement to devote much time or attention to the practical work of the pharmacist. But it is most necessary that everyone who embarks on the practice of physic should at least be able to avail himself of the adequate resources of his national Pharmacopœia. Unfortunately, there are good grounds for the oft-repeated complaint that present day medical students receive an education which is defective in so far as it relates to the writing and compounding of prescriptions.

The admirable little work which Mr. Kirkby has prepared is conveniently suited for the needs of the average student. It is based on a course of practical prescribing and dispensing elaborated by the author for members of the Manchester Medical School.

In design, execution and general suggestiveness, it merits high praise; and it may be expected to become popular, not only in the Victoria University, but in other centres of medical study.

The work is divided into convenient sections dealing with various methods, preparations, and forms of administration. In the section dealing with the forms of administration and incompatibles, all the preparations of the British Pharmacopœia and of the Formulary of the British Pharmaceutical Conference are mentioned, together with their doses.

A highly commendable feature of the work is the presentation of dispensing exercises which should be of much service to teachers as well as of assistance to students.

The forms of administration, solubilities and incompatibles of the chief official and extra-official drugs are given in convenient alphabetical arrangement, and should prove invaluable for the purposes of rapid reference.

There is also a useful collection of the words and phrases used in prescription writing, but the author has wisely reversed the customary arrangement, since,

(a) "Radio-Activity: an Elementary Treatise from the Standpoint of the Disintegration Theory." By Fredk. Soddy, M.A., Lecturer on Physical Chemistry and Radio-Activity in the University of Glasgow. With Forty Illustrations. England: The Electrician Printing and Publishing Co., Ltd.

(a) "Practical Prescribing and Dispensing for Medical Students." By William Kirkby, sometime Lecturer in Pharmacology in the Queen's College, Manchester. Pp. 169. Manchester: Sherratt and Hughes. 1904.

as he points out, the prescriber usually wishes to know the Latin equivalent of the English, and not *vice versa*, as is the case with the dispenser.

The work appears to be peculiarly free from blemishes and particularly put in practical detail. It is manifestly the work of one who is a skilled chemist, and an expert pharmacist, and who knows not only the requirements of the modern student but the best way in which his needs may be met.

We commend the work to both teachers and students.

#### DAWSON TURNER'S MEDICAL ELECTRICITY. (a)

THE rapid appearance of a fourth edition of this excellent book is in itself sufficient evidence of its excellence and popularity. As might be expected by those who have followed the trend of modern electrotherapeutics a good deal of attention has been paid to the use of sinusoidal and high-frequency currents. It is to the latter part of the book that many interested in electrical matters will at once turn. Under the heading "Therapeutic Applications" is a short but good summary of what has hitherto been done by the use of the high frequency currents. The wide divergence of the morbid conditions that are thereby relieved or cured, and the general nature of the description, register the undeveloped stage of this modern method. Dr. Turner quotes the words of a contemporary author who says:—"There can be no doubt that in high-frequency currents we have a method of treatment of distinct value. Their power of service is marked in functional nervous disturbances and in localised vascular dilatations, but their influence over diseases of the skin suggest also that they are capable of profoundly modifying general metabolism, and that they will in time be found to have a wide range of application in the treatment of diseased conditions." The remarkable result obtained in the treatment of piles and of dilated stomach might, in our opinion, have been with advantage somewhat emphasised in Dr. Turner's account. The whole of the book has been revised in the present edition and thirty fresh illustrations have been added. We echo cordially the author's hope that the tide of unqualified electrical practice will ere long be stemmed, and that the day of the instrument-maker, the nurse, and the amateur empiric will soon come to an end. Certainly the writing of good books, such as that of the author's, will help us on the road to better things.

#### GIBBONS ON REFRACTION. (b)

THE author in his preface states that he has attempted to supply students of ophthalmology with the practical information needed upon the various subjects treated.

The deductions from the various formulæ used in optics have been simplified and inserted. Whilst falling in with the accepted custom of omitting the more purely mathematical treatment of the subjects, he considers that the student should be familiar with the physics involved for the proper understanding of the subject, and consequently much of the book is occupied by the explanation of the physical phenomena met with. The author "feels that the new material and diagrams the work contains justifies its publication, so offers no apology for adding one more to the numerous books upon the same subject."

The title of this most readable and excellent dissertation on the Refraction of the Eye, is rather misleading, for it does not deal with any of the conditions usually classed as "diseases of the eye," and any one who purchases it expecting to find a description of the diseases of the eye, will find his mistake. It is a

(a) "Manual of Medical Electricity." By Dawson Turner, B.A., M.D., F.R.C.P. Ed. Medical Officer in Charge of Electrical Department in the Royal Infirmary, Edinburgh, &c. Fourth Edition. London: Baillière Tindall and Cox. 1904. Price 10s. 6d net.

(b) "The Eye, its Refraction, and Diseases. The Refraction and Functional Testing of the Eye. Complete in itself, in twenty-eight chapters, with numerous explanatory Outlines and Diagrams." By Edward E. Gibbons, M.D. Pp. 472. New York: The Macmillan Company. 1904.

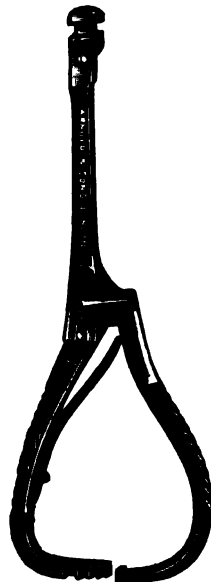
treatise on the perfection and accommodation of the eye, and the methods of functional testing, &c., but in no sense a treatise on ophthalmology, "complete in itself," as the title says. With this warning we can recommend this most carefully prepared volume to the notice of all those who require a well printed, profusely illustrated, and intelligently written treatise on the subjects dealt with.

#### ORTHMANN ON GYNÆCOLOGICAL PATHOLOGY. (a)

WE congratulate Dr. Roberts on the manner in which he has translated this valuable little work into English. Gynæcological pathology is a subject which has for some unaccountable reason been somewhat overlooked in this country. The works on general pathology pass over the special pathology of the female genital organs with a cursory notice, and gynæcological hand-books and text-books are more occupied with the therapeutical and surgical aspect of gynæcology than with its pathology. For this reason, the want of a reliable work dealing with the subject is distinctly felt, and this English edition of Orthmann's work will, we are sure, be appreciated. The book consists of two parts, the first dealing with the most important and modern methods of technique, the second with diagnosis and pathology. So far as it goes, it is good, but it is perhaps just a little short. It is illustrated by some seventy or more micro-photographs which are admirably reproduced.

#### New Appliances.

##### IMPROVED HAGEDORN'S NEEDLE HOLDER.



MR. CECIL H. LEAF, M.B. Cantab., F.R.C.S. Eng., sends us the following description of an improved needle holder:—

One drawback, he remarks, which may be urged against Hagedorn's Needle Holder is that a somewhat uncomfortable movement of the little finger is necessary to unlock it. I have therefore requested Messrs. Arnold and Sons, of West Smithfield, to construct a Hagedorn with a Macphail's catch. This renders the unlocking a comfortable process. The holder as thus modified is shown in the accompanying illustration.

#### Laboratory Notes.

WE have received from Messrs. Burroughs, Wellcome samples of various preparations of obvious value to the medical profession. We may especially mention "Soloid" of Ferric Chloride, gr. 10 (0.648 gm.). The advantages of this preparation are that it avoids the need of carrying about a solution of ferric chloride. Each product represents the amount of ferric chloride contained in 40 minims of solution of ferric chloride,

(a) "Orthmann's Handbook of Gynæcological Pathology for Practitioners and Students." Translated by C. Hubert Roberts, M.D., F.R.C.S., M.B.C.P. Physician to the Samaritan Hospital, London. Physician to the Out Patients, Queen Charlotte's Lying-in Hospital, London, &c., &c., assisted by Max L. Trechmann, F.R.C.S., London: John Bale, Son, and Danielsson, Ltd., 1904. Pp. XV. and 17.



B. P., and one, dissolved in a sufficient quantity of water to produce 40 minims, forms a solution equivalent to the official strength. By varying the quantity of water, this strength may be increased or diminished according to circumstances.

Another convenient preparation is the "Tabloid" Ferric Chloride,  $\pi$  10 (0.592 c.c.). This will be found a convenient means of administering ferric chloride, especially to patients requiring a regular course of treatment.

For the preparation of antiseptic solutions "Soloid" Mercuric Potassium Iodide, gr. 4.37 (0.283 gm.), will be found most convenient. One dissolved in ten ounces of water forms a solution of 1 in 1,000 (frequently known as mercury binioidide solution). The colour of "Soloid" Mercuric Potassium Iodide is due to a harmless ingredient added as a safeguard against errors.

The list of "Soloid" preparations includes:— "Soloid" Mercuric Potassium Iodide, gr. 1.75 (0.113 gm.), issued in tubes of twenty-five, and bottles of 100; "Soloid" Mercuric Potassium Iodide, gr. 4.37 (0.283 gm.), issued in bottles of twenty-five and 100; and "Soloid" Mercuric Potassium Iodide, gr. 8.75 (0.567 gm.), issued in bottles of twenty-five and 100.

## Medical News.

### Vaccination Frauds.

At the Old Bailey last week, Hugh Stanley Revell, 35, surgeon, who had pleaded guilty to having, whilst medical officer under the Guardians of the Wandsworth and Clapham Union, falsified certificates of vaccination and thereby defrauded the guardians of considerable sums of money, was brought up for sentence. The Recorder sentenced him to seven weeks' imprisonment, which entitled him, as he had been in custody for three months, to be at once discharged.

### Value of an Eye.

At the Congress of Ophthalmologists, which was opened at Lucerne last week, there was a discussion of the question as to what value should be placed upon an eye, injured or lost, with a view to fixing an indemnity. A number of papers on the subject, including one by Dr. Wurdemann (Milwaukee), were read. A resolution, proposed by Dr. Fuchs (Vienna), was adopted declaring that the congress had no power to draw up a definite table of damages applicable in all countries, as the laws on the subject were everywhere different. With regard to the question of the determination of the power of vision, the congress decided to elect national committees for the purpose of collecting material to be submitted to the next congress.

### The Inspection of City Restaurants.

THE Public Health Department of the London City Corporation has issued its first certificate of cleanliness under a new scheme for the attainment of cleanliness in the kitchens of restaurants and above-ground bake-houses within the City area. Dr. Collingridge, the medical officer of health for the City, states in a report that repeated representations have been made by owners and occupiers, who, having been called upon to carry out repairs and improvements, felt strongly that, as some recompense for the outlay, they should be in a position to exhibit a certificate that their premises were in a satisfactory sanitary condition. A standard of requirements has been drawn up, and further certificates will be issued after the Court of Common Council reassembles on September 22nd. With regard to restaurant kitchens, one of the suggestions is that each kitchen should have a *minimum* height of 8 ft., a *minimum* cubic capacity of 1,500 ft., except in special circumstances, and not less than 400 cubic feet per head for each person employed therein.

### The Medical Profession.

THE Winter Session, 1904-05 will commence on October 1st. The entrance examination for the Con-joint Diploma, medicine, surgery, and midwifery of the Royal College of Physicians and Surgeons, Dublin, will be held on Monday, September 26th. Entrance-form and Medical Student's Guide can be had at the Royal College of Surgeons, Stephen's Green, Dublin.

### Food Adulteration in London.

THE Local Government Board, in view of the fact that from 1894 to 1903, inclusive, only 143 samples of food—mainly milk—out of a total of 5,792 samples analysed by Dr. A. Wynter Blyth, Marylebone's public analyst, were reported to be adulterated, or 2.4 per cent. against a percentage of 11.7 throughout the Metropolis, asked how this disparity was accounted for. The Board also pointed out that, although Dr. Blyth stated before a departmental committee that he met with many samples of milk treated with borax or boracic acid, yet there was no reference in his reports during the past five years to the presence of preservatives in the milk and butter examined by him. Dr. Blyth, who is supported in his answer by the Marylebone Borough Council, has replied that the reason of Marylebone's comparative freedom from adulteration is that a systematic sampling of offenders on the "black list" has driven them further afield. He adds: "A few years ago Marylebone took more samples in proportion to its population than any other London borough, and it is reaping the advantage of its activity." Concerning the preservation of milk by means of borax, he says that, unless a standard is fixed, seeing the wide difference of professional opinion on the matter, he is unable to certify as adulterated a boraxed milk or cream, save the quantity is excessive."

### X-Rays in Blood Diseases.

DR. BOZZOLI, director of clinical medicine at the Turin University, has informed the Academy of Medicine that experiments he has made have shown that the X-rays have remarkable efficacy in some serious diseases of the blood. He says that he has cured by this means a supposedly incurable case of leucæmia.—*Electricity*.

### Disinfection of Books.

THE authorities of the various public libraries in the city of Berlin have for some time past occupied themselves with the question of disinfecting the books. To this end a number of books which had been in use in the libraries for more than two years were examined by medical experts, who declared that they contained tubercle bacilli, also dangerous germs, which were conveyed to the books by persons suffering from consumption turning the leaves over with their saliva-covered fingers.

At the meeting of the Committee of Management of the Clare County Infirmary, held on Monday, the 5th inst., the committee, through their chairman, congratulated Dr. Faris, surgeon to the infirmary, on his restoration to health, and said: "The governors were very pleased with the manner in which he always discharged his duty."

At the meeting of the Rathkeale Board of Guardians, held on Wednesday, the 7th instant, a letter was read from the I. L. G. Board refusing to sanction the payment of an operation fee to Dr. Thomas Hayes. They based their refusal on the ground that Dr. Hayes was the medical officer of the workhouse, although he was on his holidays on the occasion. The facts of the case are: Dr. Hayes, though on his holidays, was still at home, when he was requisitioned by his medical substitute to perform an urgent operation on an accident case. He immediately complied with the call and is now refused his legitimate fee. Suppose he had gone one hundred miles from home and been similarly requisitioned, would he not be entitled to charge? Does distance make the difference?"

## 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.

### A POPULAR FALLACY.

A COMMON popular error is that a doctor is compelled to go to a case whenever he is sent for—as though he were a public official subsidised out of the public funds. Indeed, this was the idea of a jurymen at the inquest upon a recent Manchester case, to which the doctor had declined to go.

"What are you paid for, I should like to know?" he indignantly asked the doctor.

"Do you pay me?" the latter inquired.

"Aren't you paid out of the rates?" then asked the sapient jurymen.

M.R.C.P.—The reduction in space given to your Institution in our Students' Number was unavoidable.

FIFTH YEAR.—The next examination of the Medico-Psychological Society will be held on November 7th. You will find the necessary particulars on reference to our advertising columns.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, SEPTEMBER 21st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chelms Street, W.C.).—4 p.m. Mr. J. Clarke: Clinique. (Surgical.)

THURSDAY, SEPTEMBER 22nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chelms Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.)

FRIDAY, SEPTEMBER 23rd.

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

## Vacancies.

Birkenhead Borough Hospital.—Junior Resident House Surgeon. Salary £80 per annum. Applications to the Honorary Secretary.

Horton Infirmary, Banbury.—House Surgeon. Salary £80 per annum, with board and residence in the Infirmary. Applications to the Honorary Secretary, 21 Marlborough Road, Banbury.

Halifax Union Poor-law Hospital.—Resident Medical Officer. Salary £120 per annum, with apartments, rations, and washing. Applications to Arthur T. Longbottom, 4 Carlton Street, Halifax.

Liverpool City Infectious Diseases Hospitals.—Assistant Resident Medical Officer. Salary £120 per annum, with board, washing, and lodging at the hospital. Applications to the Chairman of the Port Sanitary and Hospitals Committee, c/o Town Clerk, Municipal Office, Liverpool.

West Riding of the County of York—Stories Hall Asylum, Kirkburton, near Huddersfield.—Assistant Medical Officer. Salary £140 per annum, with furnished rooms, board, attendance, and washing. Applications to the Medical Superintendent.

Manchester Corporation—Monnal 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.

Ancoats Hospital, Manchester.—Resident House Physician. Salary £80 per annum, with board, residence, &c. Applications to Saml. Baron, Secretary.

Kidderminster Infirmary and Children's Hospital.—House Surgeon. Salary £120 per annum, with rooms in the Infirmary and attendance. Applications should be addressed to the Secretary on or before September 23rd. Canvassing not allowed.

Croydon Union.—Resident Assistant Medical Superintendent and Dispenser at the Infirmary, Mayday Road, Croydon. Salary £180 per annum, with furnished apartments, rations as per scale, and washing. Applications to Harry List Clerk to the Guardians, Union Offices, Mayday Road, Thornton Heath.

Newcastle-upon-Tyne City Hospital for Infectious Diseases.—Resident Medical Officer. Salary £100 per annum, with board, lodging, &c. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

National Maternity Hospital, Dublin.—Intern Assistant Master. Salary £50 per annum. Immediate application to Secretary, Holles Street. (See advt.)

## Appointments.

HAYNE, LOUIS B., M.D., B.C. Cantab., Honorary Medical Officer to Out-patients at the Harrogate Infirmary.

HUST, A. W. D. L.R.C.P.Lond., M.B.C.S.Eng., Surgeon to the Loyal Crown Lodge of Oddfellows at Chagford (Devon).

KIRTON, MARTIN A., M.B.C.S.Eng., L.R.C.P.Lond., Public Vaccinator for the No. 2 District by the Devonport Board of Guardians.

LEVICK, G. K., M.B.Lond., Medical Officer of Health to the Havant Urban District Council.

MOSEY, SYDNEY G., M.B.Oxon., Medical Officer of Health of South Shields.

RYAN, RICHARD P., F.R.C.S.Irel., Public Vaccinator to the First District by the Devonport Board of Guardians.

SAYER, THOMAS, M.R.C.S.Eng., L.R.C.P.Lond., Medical Officer and Public Vaccinator for the Kirklington District of the Bedale Union and for the Pickhill District of the Thirsk Union.

## Births.

BLOMFIELD.—On Sept. 12th, at Horsefair, Pontefract, Yorks, the wife of George Wills Blomfield, M.D., of a son.

ECCLES.—On September 18th, at 124 Harley Street, London, the wife of W. McAdam Eccles, M.S., F.R.C.S., of a son.

LAWLESS.—On Saturday, September 10th, the wife of George R. Lawless, F.R.C.S.I., Medical Superintendent, Armagh District Asylum, of a daughter.

WEBSTER.—On Aug. 28th, at Toorak, Melbourne, Australia, the wife of Dr. Percy S. Webster, of a son.

WHIRLAN.—On September 12th, at 28 Synnott Place, Dublin, the wife of James A. Whelan, L.R.C.S.I., of a son.

## Marriages.

COAD—YUILL.—On September 17th, at St. Mary Abbott's Church Kensington, London, Stanley Allan Coad, M.B.C.S., L.R.C.P., 7 Elgin Avenue, London, W., third son of Thomas Coad, late of the Horse Guards, Whitehall, to Sarah youngest daughter of the late John Yuill Hill side, Partick Hill Glasgow.

TURNER—HAMILTON.—On September 14th, at the Parish Church, Tavistock, Devon, William Turner, M.S. (London), F.R.C.S., of 53 Queen Anne Street, Cavendish Square, London, to Lily, only daughter of John Kerr Hamilton, of St. Bimons's, Tavistock.

## Deaths.

BENHAM.—On September 14th, Harry Arthur Benham, M.D., Medical Superintendent of the Bristol City and County Asylum, aged 49.

BIDDLE.—On September 18th, at Charlton Lodge Kingston-on-Thames, Frances Eliza Lydia, the beloved wife of Daniel Biddle, M.B.C.S.Eng., and L.S.A.Lond.

HARDY.—On September 16th, at West Haddon, Euby George Hardy, M.B.C.S., in his 85th year.

HUTCHINSON.—On September 15th at his residence, Ford, Branksome Park, Bournemouth, Samuel John Hutchinson, M.B.C.S., L.D.S. Lond., of 64 Brook Street, Grosvenor Square, London, aged 58.

JAMESON.—On September 13th, at Newlands, Eltham, Surrey, General James Jameson, C.B., &c., late Director-General Army Medical Service, aged 67.

## OPERATIONS.—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopaedic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Gt. Ormond Street (2.30 a.m.), Gt. Northern Central (9.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (2.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynaecological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (2.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (2.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopaedic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (10 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), St. George's (2 p.m.), St. Mary's (2.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynaecological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopaedic (2 p.m.), City Orthopaedic (4 p.m.), Great Northern Central (2.30 p.m.), West London (1.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (1.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.m.).

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

Vol. CXXIX.

WEDNESDAY, SEPTEMBER 28, 1904.

No. 13.

## Original Communications.

### THE HOSPITAL ISOLATION OF SCARLET FEVER.

By A. MEARNS FRASER, M.D., C.M., D.P.H.  
Camb., &c.,

Medical Officer of Health for Portsmouth.

No branch of sanitation is receiving more attention at the present time than that which comprises the prevention of infectious diseases by aggregation of the cases in a so-called isolation hospital. It is therefore interesting to remember that the establishment of isolation hospitals all over the kingdom was not the result of the careful observation of the successful working of a hospital in the prevention of the disease; the now almost universal adoption of isolation hospitals is based on the idea that it must inevitably be beneficial to remove every case of infectious disease from the house in which it exists to a place where it can be kept by itself away from all other members of the community. Now, this is a common-sense view that appealed to all, and one is quite prepared for the feverish anxiety of some medical officers of health to have every infectious case in their district removed at once to the hospital, and one can quite appreciate the action of most medical officers of health in regarding the isolation hospital as their principal weapon for fighting infectious disease. It was, and is now, though possibly to a less extent, usual, if infectious disease had not been very prevalent in a district, to attribute this to the provision of an isolation hospital, and in annual reports on such districts congratulations were offered to the sanitary authority on their foresight in providing such isolation hospital accommodation; on the other hand, if infectious disease had been more prevalent than usual one often noticed regrets expressed that the isolation hospital accommodation had proved insufficient to cope with the outbreak; the disease in question had spread, and sanitary authorities were urged to make further provision in the future.

During the last year or two, however, in the minds of a number of medical officers of health there has arisen considerable doubt as to whether the benefit of isolation hospitals is really so great as has generally been supposed; some, indeed, having got past the stage of doubt, insist that at any rate as regards the prevention of scarlet fever isolation hospitals are of little use. The reasons that have brought about this change of thought are not far to seek.

The isolation of scarlet fever cases in hospitals

has been practised in many large towns for about twenty years: this is a long enough period for the system to be effectually tried, and in those places at which it has been most persistently carried out there should surely be some diminution in the scarlet fever prevalence. This, however, is not the case: towns isolating a large percentage of their scarlet fever cases can show no appreciable improvement in this respect over other towns which have isolated few or none; curiously enough, too, some towns which have isolated very few of their cases show a greater diminution than those which have practised extensive isolation. The case of Birmingham has been quoted; this city, which is second only to Huddersfield in the extent of isolation practised (84 per cent. of the cases of scarlet fever being isolated during the ten years 1890-1899), actually had an attack-rate in 1902 of 9 per 1,000 population, an attack-rate larger than in any previous year since 1890 and higher than in any other large town in the kingdom in that year. Indeed, a return of the scarlet fever "attack-rates" existing in the various towns compared with the amount of hospital isolation practised affords very instructive reading, and anyone interested in the question cannot do better than obtain a copy of Dr. Killick Millard's paper on the subject. (a)

To what, then, can this non-success of the isolation hospital in the control of scarlet fever be attributed, and what are the reasons which have withheld the results so confidently anticipated by sanitarians at the inception of the isolation hospital? I believe they may be found in the fact that the originators of the system overlooked some of the difficulties in the way of securing complete hospital isolation. Under the Infectious Diseases (Notification) Act it was doubtless anticipated that in the first place every case of scarlet fever occurring in a district would be promptly notified to the medical officer of health, and, if incapable of being isolated at home, would be promptly removed to the isolation hospital; and, secondly, it was believed that once admitted to hospital it would remain there till free from all infection, so that on its discharge there need be no fear of its again spreading the disease.

In practice, however, this ideal has never been attained. In the first place it is well known that in every town a number of cases of scarlet fever occur which are of so slight a character that no medical man is called in and they are only discovered, if at all, through investigating the source of other and possibly more severe cases which have arisen from

(a) "The Influence of Hospital Isolation in Scarlet Fever." By C. Killick Millard, M.D., D.Sc. London: Ebbman, Ltd.

those originally unrecognised. To these must be added cases which are concealed, either because the parents are afraid of their children being compelled to go to hospital, or because it is feared that the knowledge of the existence of a case of scarlet fever in the house may interfere with the work of the wage-earners of the household. Here, then, is one reason for the want of success of the isolation hospital; there is, however, an even more important factor.

I have said that the object of the isolation hospital is to retain the case of scarlet fever until it can safely be returned to the community without fear of again spreading the disease. It must be obvious that this is a fundamental principle of the system, the complete attainment of which is an absolute essential for the success of the isolation hospital, yet again, in actual practice this ideal has never been attained. I believe there is no hospital superintendent in the kingdom who would be prepared to guarantee that any particular individual, on his or her discharge from the hospital, was actually free from infection, and incapable of again spreading the disease on mixing with other susceptible members of the community. Indeed, "return" cases are so common that paper after paper has been written, and innumerable discussions have taken place to find out how it was that scarlet fever should still be spread by patients who, to all appearances, were discharged from hospitals perfectly free from infection. Further, it is now the practice in most towns to issue printed notices that the patient should on his discharge from hospital be kept away from school and other children for periods varying from a week to a month. In spite of these precautions, however, return cases persist with a disheartening regularity.

The above are, I believe, the two chief explanations why isolation hospitals do not, and, moreover, are not likely, so far as we can see, to control the prevalence of scarlet fever in a town. And if it cannot be shown that isolation hospitals control the disease, there at once disappears the chief *raison d'être* for their existence.

I must mention, however, another argument that is often urged in favour of hospitals—namely, the actual benefit to the patient from the superior nursing he will in most cases obtain in hospital, compared with that provided at home. Here, again, the experience of past years has not supported this contention, for the number of cases of adenitis, rhinorrhœa, and otorrhœa that occur periodically in every scarlet fever ward, to say nothing of others which, admitted with scarlet fever, contract in addition such diseases as measles, whooping-cough, diphtheria, and chicken-pox, are so numerous as, in the opinion of many, to counteract any extra advantage that may be derived from trained hospital nursing.

There is yet another side of the question that must be considered, and one that I have in the past laid considerable stress upon, namely, the financial aspect.

I believe that in the departments of most medical officers of health one of the principal, if not actually the largest item of expenditure is the isolation hospital. Now scarlet fever, although, as known at present, an exceptionally mild disease, yet is so prevalent that 75 per cent., and often more, of the accommodation at isolation hospitals in large towns is nominally taken up by this disease alone. Millions have been spent on the erection of isolation hospitals and hundreds of thousands are annually

spent on their maintenance. Now as by far the larger part of the cost of the erection and maintenance of hospitals is undoubtedly incurred through an attempt to control scarlet fever, the reflection must occur whether sufficient justification exists for the expenditure of such large sums of money on a disease that, with the exception only of chicken-pox, causes a slighter mortality than any of the common infectious diseases. If the hospitals were really controlling the disease, and if year after year, as isolation methods improved, a corresponding diminution in its prevalence were noticeable, then possibly some excuse for the expenditure might, in spite of the mildness of the disease, be found. But as the facts exist at present, with the annual expenditure on isolation hospitals growing larger and larger, and at the same time scarlet fever, if not becoming more prevalent, at least not showing any diminution, then it does indeed seem that the time has arrived when an official inquiry as to the advisability of modifying or improving the present system should be instituted.

If it should be found that, owing to our inability to define the length of the infectivity of the disease, not much improvement in the present method can be hoped for, then let the money devoted to scarlet fever be spent in other directions, such as the betterment of the houses of the working classes. Money spent in this latter direction cannot fail to give some definite beneficial return, and it is to my mind a question whether, if the same money which has been expended in the past on the isolation of scarlet fever had been devoted to clearing away slum property, we should have had far better results to show, not only in the improved dwellings of the working classes, but also indirectly in that diminution of infectious disease which always results from the improvement of the homes of the poor. One word in conclusion: in the above remarks and in previous writings on the subject of isolation hospitals, I have limited myself entirely to their connection with scarlet fever, and nothing that I have said applies to enteric fever, small-pox, or diphtheria. Moreover, I am not advocating the total abolition of the hospital isolation of scarlet fever; under existing legal enactments it is difficult to see how sanitary authorities can avoid providing accommodation for a certain small percentage of the cases that occur; inasmuch as a dairyman, or a tailor and a few others are legally prevented from pursuing their usual employment whilst scarlet fever is present in their houses, it is only right that provision should be made for removing and treating these cases elsewhere. What I do contend, however, is that it is quite time a thorough investigation was held to ascertain if the wholesale isolation of the mild cases of scarlet fever that is practised at present is worth the large sums of money expended upon it, and incidentally to have an authoritative opinion as to whether there are not good reasons for supposing that the money now spent on the hospital isolation of scarlet fever cannot be more profitably employed in other directions.

In an inquiry of this nature the evidence to be sifted will be considerable, and it is essential that it should be conducted by men of weight and standing. Personally, I should like to see it the subject of a Royal Commission; moreover, as suggested by Dr. Millard, laymen might with advantage be on such a board of inquiry; the question is largely one of finance, and it would be of

great value to have the opinion of men of experience in local government administration, men who, leaving the purely medical aspect to their medical *confères*, would be able to pronounce a judgment as to whether the results obtained from the hospital isolation of scarlet fever as at present practised afforded an adequate return to sanitary authorities for the expenditure involved.

### SCIATICA. (a)

By J. E. HARBURN, L.R.C.P., L.R.C.S.Ed.,  
Buxton.

THE subject which I desire to briefly draw your attention to is one of considerable interest on account of the intractable nature of the complaint, and also by reason of the difficulty which is often experienced in affording relief. This is evidenced by the numerous remedies which have at various times been suggested for its treatment.

Judging from the large and increasing number of cases which are sent to health resorts year by year for special treatment, it would seem that sciatica in many instances tends to assume a chronic course, and exerts a most debilitating and depressing effect on the health of those who suffer from it. During the past seven years over 400 cases have been treated in the practice which is conducted by my colleague, Dr. Armstrong, and myself at Buxton; and it is from consideration of the notes of these cases that I have drawn the observations which I venture to bring before you to-day.

The term "sciatica" is somewhat loosely used to describe all painful conditions of the sciatic nerve or its branches, but experience shows that the following classification is desirable:—

- (a) Sciatic neuralgia.
- (b) Sciatic perineuritis.
- (c) Sciatic neuritis.

(a) Sciatic neuralgia is frequently of a very temporary character and may be simply functional, probably showing no change whatever in the sheath of the nerve. When the general health of the patient is low, however, it is often of considerable duration. The pain may be intermittent, and there is usually tenderness at two or three points of the nerve. It often occurs in patients who have neuralgia in other parts.

(b) Sciatic perineuritis sometimes precedes or follows neuritis, and in these cases we have to deal with the symptoms of sciatic neuralgia and sciatic neuritis. There is generally tenderness along the whole of the upper third of the nerve, and the surface temperature of the limb may be reduced. The patellar reflex may be intensified.

(c) Sciatic neuritis is infinitely the most serious and intractable form of the disease, and a large proportion of the most refractory cases come under this heading. There is great tenderness not only of the nerve itself, but over the surrounding parts. The temperature of the limb is always reduced; there is tingling and numbness and muscular atrophy in the later stages. The patellar reflex is sometimes lost, and cases of this variety have been mistaken for locomotor ataxia.

Accurate differentiation is of the utmost importance both as regards prognosis and treatment, for while cases of the first group can, as a rule, be speedily cured, those in the second are more troublesome, and in the third the most refractory

of all. As I hope to show later, the treatment indicated varies greatly. Methods which are of service in Class A are absolutely harmful in Classes B and C.

The causes of sciatica are in some cases difficult to trace. In the great majority of cases, however, there is a gouty or rheumatic taint present, and in a striking number of instances the patients had been subjected to great worry and over-pressure, which had lowered the nerve tone, probably inducing defective metabolism and tardy excretion of body waste. A large number of these cases occurred in over-worked business and professional men.

The exciting causes of sciatica are cold, damp, and traumatism. Possible pressure within the pelvis from constipation, uterine displacements, tumours and aneurysms must not be lost sight of. Neuritis is often caused by the action of such poisons as lead, arsenic, and alcohol, and it should be remembered that the subjects of glycosuria and diabetes are very liable to this affection of the nerve. In not a few cases sciatic neuritis occurs as a sequel to influenza.

*Treatment: Acute Sciatica.*—Whatever variety of the disease is present, in the acute stage rest is absolutely essential. In many instances a well-padded splint extending from the spine to the foot is of great service. Dry heat applied by means of the Tallerman apparatus, or of its offshoots, the Greville or Dowsing methods, or if these are not available, by the application of indiarubber hot-water bottles, will be found most effective. With regard to drugs, no combination has, in our experience, been so effective as the following:—Aspirin, 6 grains; phenacetin, 5 grains; salicylate of quinine, 2 grains; and codeinæ,  $\frac{1}{4}$  to  $\frac{1}{2}$  grain.

The bowels should be well cleared with small doses of calomel followed by salines. In those cases in which the pain is not relieved an occasional injection of morphia with atropine may be necessary, but this is a remedy which should be used with great caution and not too frequently repeated, as it tends to interfere with the excretion of body waste, and may also lead to the establishment of the morphia habit.

*Subacute Sciatica.*—It is in this stage of the trouble that the various spas become of service. In Buxton we have found nothing so successful as the half combined bath. The patient sits in a vapour bath which comes up to the waist line only; this, while not so exhausting as the full vapour bath, allows a higher temperature to be borne by the affected parts. Thus a temperature up to 115° F. can be tolerated with advantage for from ten to fifteen minutes. At the end of this time the patient sits in a bath of the Buxton thermal water, heated to a temperature of 95° for eight minutes, and during the last three minutes a hot under-current douche at 102° to 110° is applied to the affected limb.

In this stage also electricity in various forms is used with excellent results. The sinusoidal electric water bath (200 alternations per second), or the high frequency currents of D'Arsonval, are the most useful, as they have a distinctly anæsthetic effect upon the nerve, whilst improving its nutrition. Acupuncture has often been found beneficial at this stage, as has also the application of menthol plaster or a blister over the head of the affected nerve, or the use of the thermo-cautery. The administration of fairly large doses (10 to 15 grains) of iodide of potassium three times a day

for three or four days is sometimes beneficial, and in some instances the combination of this with arsenic has been of great service.

*Chronic Sciatica.*—In the treatment of the chronic forms of sciatica it is essential that distinction should, as far as possible, be made between true neuritis and other forms of this complaint. Where neuritis is not present the Aix massage bath with the douche applied to the painful part is of great value, as are also dry and electric massage, followed by gentle stretching of the nerve in cases where adhesions are present. The Buxton swimming bath at the natural temperature of 82° F. is one of the most valuable remedies at our disposal.

In true neuritis, however, massage is, as a rule, most harmful, and nerve-stretching is quite contra-indicated. The warm immersion bath with hot under-water douche or the natural swimming bath will greatly help these patients; and electricity in the form of the constant current ascending and descending over the affected nerve, or the constant current bath, is of much service.

The affected limb should be kept warm by the wearing of double socks and pants. Dr. Farquhar, of Marlborough, speaks very highly of the injection of one-third grain of pilocarpin nitrate on alternate days for two or three weeks, except in cases where there is organic mischief. In some very obstinate cases of sciatica the injection of osmic acid has been used with success, but it is a drastic and uncertain remedy.

If the pain is perpetuated by adhesions which gentle nerve-stretching does not break down, forcible stretching under anæsthesia may be resorted to.

In some cases where all else has failed the nerve has been cut down on and forcibly stretched, and in two cases it was found that the sheath and nerve were so intimately connected that the former had to be dissected off. Dr. Crawford Renton, of Glasgow, has published a series of remarkable cases in which this condition was found.

## PROLONGED LACTEAL SECRETION AS A CAUSE OF CONSTITUTIONAL DEBILITY(a)

By DR. L. CHEINISSE,

Ex-Interne of the Montpellier Hospitals, Laureat of the Faculty of Medicine.

THE mammary gland of the female is intimately associated, physiologically, with the genital function, and closely resembles that gland in the male, from which, indeed, it only begins to differ at the onset of puberty. Essentially an intermittent function, the mechanism of lacteal secretion is usually set up by reflex stimulation such as the presence of a foetus in the uterus or suction applied to the nipples by the infant. These conditions, however, by no means comprise the whole of the natural history of the mammary gland, for there are many other exciting causes capable of starting or maintaining the secretion. Though rather rare than otherwise, instances of the kind are frequent enough for them to have been recognised and classified. Some twenty years ago, Dr. R. Duval went into the subject thoroughly and described five categories of non-puerperal lacteal secretion: (1) Cases in which the secretion is prompted by the menstrual function; (2) cases in which the stimulus comes from a tumour of the breast; (3) cases in which there is secretion of milk in connection with some utero-ovarian affection; (4) cases in which it is set up

by mechanical or psychical stimulation unassociated with any structural changes in organs; and (5) instances of persistent lacteal secretion after the menopause.

I recently had under observation a patient who exhibited a further anomaly of the lacteal function, one which possesses something more than a pathological interest, since it may determine consequences very detrimental to the health and comfort of the victim. The patient was a young primipara, who, in consequence of the inadequacy of her secretion of milk was constrained to supplement the supply by a proportion of cow's milk. Five months later she was obliged to absent herself for some weeks, and the child had therefore to be weaned at short notice. Two days later the breasts had become swollen and painful, and relief was obtained by emptying them by aspirating the milk. She continued this practice for a fortnight several times daily to begin with, and subsequently, as the quantity of milk diminished, less frequently. The gland, however, went on secreting, though not in any large amount, but milk flowed away when even slight pressure was applied to the breast, and during the night enough escaped to wet the front of the night-dress. The secretion increased in amount on the slightest fatigue, even after moderate walking. The inconvenience did not go beyond this, so the lady did not consider it necessary to seek advice on the subject.

She was living at this time under very healthy conditions, but she noticed that she was losing weight and had become subject to attacks of palpitation. The family physician, to whom she applied without mentioning anything about the persistence of the secretion, recommended a change of air and the ordinary remedies for anæmia. This treatment failed to do her any good, and as she continued to lose flesh and strength she ultimately consulted me. I, too, was struck by the manifest anæmia, and, for a time, I was unable to discover any plausible explanation of its occurrence. The heart and lungs appeared to be normal, and the abdominal organs revealed no evidence of disease. Menstruation, which had recurred soon after the infant had been weaned, had since been normal in date and amount.

This was as far as I had got with my investigation when one day, while auscultating the heart, I noticed that the pressure of the stethoscope brought some drops of milk from the left nipple. On squeezing the mamma more milk came away, and on repeating the experience on the other side the same effect was produced. Naturally, my first thought was that the lady was again pregnant, but apart from the fact that she had menstruated regularly I was unable to discover any other sign to confirm my assumption. Moreover, on questioning her, I found that, as a matter of fact, the secretion had never ceased since her child was weaned, that is to say, twenty-six months previously. She said she did not attribute any importance to the presence of milk in the breast, and from motives of modesty had abstained from mentioning the matter. It at once occurred to me that there might be a close relationship between the persistence of this secretion and the disturbances of nutrition which the patient presented, and which had resisted the usual stomachic treatment. Before making up my mind I thought it desirable to ascertain the exact nature of the secretion. Under the microscope I found colostrum corpuscles, true milk globules, and a few epithelial cells undergoing disintegration. These figured elements were isolated and disassociated—a circumstance which, according to Palazzi, justifies the presumption that the secretion is not the outcome of a fresh pregnancy, but is due to persistence of the function long after the period of lactation.

With these data before me and with the object of arresting the lacteal secretion, I prescribed ten-grain doses of antipyrine three times daily, in cachet. In the course of a few days the patient found that milk could no longer be squeezed out of the breasts. It may be simple coincidence, but the fact remains that from this date the patient gradually improved in health.

(a) See *La Semaine Médicale*, July 13th, 1904.



and soon ceased to experience any symptoms, although no other treatment was resorted to; in fact, within a few weeks she had quite recovered her normal standard of health.

This case is interesting not only as an example of remarkable persistence of the lacteal secretion, but also, and more particularly, on account of the influence which this abnormality exerted on the general health. Exceptional as the occurrence may appear at first sight, it is in reality by no means unique. Putting aside for the moment the question of the impairment of health caused by this anomalous secretion, I should like to discuss the persistence itself. Under ordinary circumstances the hypertrophy and secretory activity of the gland are limited to the period of lactation, and when this has come to an end, though the cells continue to secrete for the first few days after the weaning of the child, the alveolæ then begin slowly to retract. Large numbers of fat cells are detached from the membrane and undergo transformation into a residue which is ultimately in great part absorbed. The gland recedes and remains quiescent until another pregnancy summons it from the reserve and starts it again on active service. That is the general law, and although it admits of certain exceptions, these departures from the normal have not, so far, received sufficient attention. I note, indeed, that in three recent works on the lacteal function the only aberration mentioned is that in some countries, Hungary for instance, women of the labouring classes continue to suckle their infants till the age of three years, and even more. Observations of this kind have obviously nothing in common with the subject under consideration, which concerns the persistence of the lacteal function long after the period of lactation or even in the absence of lactation, an instance of which is recorded by Tceitline in a woman in whom the secretion of milk was maintained for five years, although she had never given her infant the breast. This case, however, is not on all fours with my own, in that the patient was the subject of chronic metritis.

But, leaving on one side cases in which the milk secretion is under the empire of some affection of the uterus or ovaries, we must admit that there are cases in which weaning the child does not put a stop to the secretion. Dr. Opitz, protesting against the distinction usually inculcated between colostrum and milk, according as the fluid does or does not contain colostrum corpuscles, says: "We meet with cases in which there is a copious secretion of milk a year or more after the normal period of lactation has terminated—a secretion which contains colostrum corpuscles, but is microscopically indistinguishable from milk." Palazzi, on the other hand, refers to three women with persistent secretion of milk, who had weaned their infants respectively seven, seventeen, and thirty-two months previously.

Not only may the secretion of milk continue for long periods of time, but it may be very abundant, amounting, it may be, to genuine galactorrhœa. Instances of this kind are on record in medical literature, and in the Transactions of medical societies, which, although not referred to in works specially devoted to anomalies of lactation, are nevertheless worthy of attention.

Moir reports the case of a woman in whom, although she had never brought up any of her children at the breast, the secretion invariably persisted until the third month of the next pregnancy. After the birth of her second child, the function remained active for eighteen months, after the third for two years, after the fourth for twenty-five months, and after the fifth for twenty-four months, when she had a miscarriage, since which she has not again been pregnant. Kneeland publishes notes of a case in which a woman, æt. 35, who had given birth to a child five years previously, still continued to secrete milk, though she gave up suckling the child at the end of two years. Dr. Gibbons brought before the Obstetrical Society of London a case in which both breasts secreted freely for some weeks after delivery, when the milk disappeared from the right breast, soon after which she

weaned the child; but the left breast continued to secrete over half a pint of milk daily for eleven months, when it suddenly ceased on the re-appearance of menstruation.

It is generally recognised that when lactation is prolonged beyond a year or eighteen months it entails more or less serious drawbacks for the mother. Marion Sims, for example, mentions cases of menorrhagia caused by "superlactation," and Sinclair has shown that the sudden termination of unduly prolonged lactation may determine hyperæmia of the utero-ovarian apparatus, and by promoting too pronounced involution of these organs may determine complete or partial prolapse of the uterus. Apart from these complications, we should take cognisance of the constitutional disturbances (exhaustion), and even psychological troubles that have been observed after prolonged lactation.

We now have to ask ourselves whether simple persistence of secretion after the cessation of lactation is capable of bringing about the same troubles. Now it is evident that when the secretion of milk is so copious as to merit the designation of galactorrhœa, this glandular activity entails the same consequences as puerperal galactorrhœa, which, like any other pathological secretion, may modify the tenor of organic exchanges and cause very pronounced denutrition. Dr. Nussbaum states that he has met with several cases in which the mammary glands have persisted in secreting milk for one or two years after weaning, and in such quantity as to be described as galactorrhœa. This was followed by impoverishment of the blood, marked prostration, and loss of control over the emotions, symptoms which he attributes to this persistent and considerable loss of nutrient fluid. In one case the patient, a woman, æt. 37, had suckled her infant until nine months of age, and eighteen months later she still presented bilateral galactorrhœa with consequent exhaustion. A second case was that of a woman, æt. 36, who had had two pregnancies. The child had been weaned at nine months, but the secretion of milk did not cease, and she consulted Dr. Nussbaum a year later, when she presented symptoms suggestive of ulcer of the stomach. In both these cases the administration of laxatives and antipyrine, together with compression of the breasts, had for effect first to reduce, and ultimately to determine, the flow. It should be mentioned that in both cases there were uterine complications, catarrhal endometritis in one and retroflexion of the uterus with catarrh in the second, so it may be that they belong in reality to the group of cases of persistent lacteal secretion dependent upon irritation of the utero-ovarian apparatus. However that may be, the history shows the grave consequences that may be brought about by prolonged and excessive functional activity of the mammae.

Commenting on these two cases, Dr. Nussbaum remarks that he had only been enabled to discover one instance of persistent lacteal secretion (Tceitline), which he had looked upon as unique. As a matter of fact, a number of cases of the kind have been published, and attention had previously been called to the disastrous consequences of this abnormal occurrence. In a work published in 1859, Claude Bernard mentions that instances were met with of women continuing to secrete milk over long periods of time with consequent prostration, and he suggests that diminished activity on the part of the sympathetic nervous system might account for the abnormal function by stimulating excessive circulation. That assumption, he argued, was borne out by the action of electricity, which caused contraction of the blood-vessels by direct stimulation of the gland itself or of the sympathetic nervous system.

These quotations, however, refer only to exhaustion caused by an *exaggeration* of the function, not only in respect of duration but also in respect of quantity. In my case the interesting feature is the evidence that prolonged activity of the secretory apparatus may determine exhaustion even apart from galactorrhœa. Nor do I suppose for a moment that the case is exceptional. In all probability the occurrence is far more

frequent than one might be tempted to suppose, and if it escapes our observation it is simply because the patient does not call the doctor's attention to the abnormal secretion either from motives of mistaken modesty or merely because she does not attach any importance to the fact. In any event, I have satisfied myself that the observation is by no means an isolated phenomenon. Dr. Beltz, for instance, brought before the Medical Society of Rheims the case of a woman who, after her first labour, weaned the infant on the eighth day, yet the secretion persisted for four years without obvious galactorrhœa, since the milk did not flow away of itself. During the menstrual periods, far from diminishing, the flow increased. This patient, he states, presented no very definite symptoms, but she complained of pains in the stomach and the back, debility and general lassitude. He concludes by insisting on the necessity of arresting the flow, which, he opined, was the probable source of the constitutional impairment.

The first lesson to be drawn from these facts is that we must not ridicule the popular idea of the necessity of "getting rid of the milk" when the child is weaned. However absurd may seem the stories that are told of the milk having "gone to the leg," or what not, there may be a substratum of truth in the popular belief. On the other hand, the idea that denutrition can possibly be brought about by persistence of the lacteal secretion is worth bearing in mind, and it should occur to us whenever we have to do with a patient who is suffering from anæmia and emaciation without obvious cause, especially as moderate persistence of the secretion may very well be overlooked by the patient when she applies for advice. Unless the real cause of the constitutional impairment be discovered, we may run through the whole therapeutical arsenal without effecting an improvement.

### Clinical Records.

#### NOTE ON A CASE OF SIMULATED UNILATERAL AMAUROSIS, FOLLOWING AN INJURY RECEIVED UNDER THE WORKMAN'S COMPENSATION ACT.

By THEODORE A. W. OGG, L.R.C.S.Edin., L.R.C.P.Edin., &c.

THE following case occurred in a workman who received a slight injury to the right side of his head during his employment. The injury was of the nature of a bruise and the workman complained of complete loss of sight in the right eye with partial blindness in the left as the result of and following the injury, and as a consequence, inability to follow his employment.

He was wearing at this time a pair of spectacles belonging to someone else of his household. On examination the eyes presented nothing abnormal, and he was then tested with various coloured glasses, through which he was able quite accurately to distinguish the colour of a candle flame, seen, he said, with the left eye.

An opaque disc was then introduced (unknown to him) opposite the left eye and he was then asked the colour he saw, when he again gave the correct colour, stating repeatedly when asked that he saw the flame with his left eye, which, of course, was impossible.

He visited me on the afternoon of the following day and said that his sight was so considerably improved as to be now almost quite well and he would again resume work. I have recorded this case as one of many that are liable to occur under the Workman's Compensation Act, where I have found workmen quite content to remain idle on

half-pay, although a family may depend on their earnings, having no doubt in view the offer of a sum in full settlement of their claim against their employer.

### British Health Resorts.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

#### XI.—LYNTON AND LYNMOUTH.

THESE twin villages of North Devon have long been beloved by artists and quiet holiday-makers, but their advantages as desirable health stations have been much overlooked. The peculiar situation, the sheltered glens, the wooded hills, the free exposure to sun and sea, afford conditions which may well prove invaluable in the hygienic management and therapeutic treatment of many delicate persons and not a few actual invalids.

Lynton, which forms the key to Exmoor, is situated on the cliff side 428 feet above the sea, while Lynmouth nestles around the East and West Lynn after their course through rocky and well-wooded gorges. The natural conditions are peculiarly suited to the requirements of the health seeker.

Science and art have also done much to furnish the necessities for hygienic comfort. The water supply is excellent, the drainage good, hotel and lodging-house accommodation is plentiful, and sport in plenty is available for those in a condition to participate.

The thoughtful student and the overworked public man will find the neighbourhood peculiarly rich in interesting features, which afford instruction for mind while at the same time securing recreation for body. (a)

After a careful personal investigation of Lynton and Lynmouth, we are of opinion that it may be recommended as a particularly desirable resting station for busy workers, who, through excessive indulgence in work and worry, feel the fret and fray, the stress and strain of business and profession, and develop conditions which are conveniently summarised as neurasthenia.

The district offers splendid opportunities for graduated hill climbing. Pulmonary diseases and affections benefited by open-air methods should do well during summer months at Lynton.

Persons having heart and other vascular disease would be well advised to select a less hilly station.

Lynton can be reached from Waterloo (L.S.W.R.) in about six and a half hours, the latter twenty miles of the journey being by light railway from Barnstaple. (b)

The vigorous will enjoy the picturesque method of approach by a coach drive of about eighteen miles from Minehead (G.W.R. route).

Visitors may also reach Lynton from Paddington (G.W.R.) *via* Taunton and Barnstaple.

At some seasons of the year, steamers from Bristol stop at Lynmouth, but as there is no pier the landing is difficult, and in rough weather quite unsuited to the invalid.

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, September 25th, 1904.  
CORYZA.

ACUTE coryza, popularly called "cold in the head," is, as everyone knows, a very troublesome affection in adults, while in infants it frequently compromises their existence.

Several remedies, both internal and external, have been tried with varying success.

(a) See new volume (No. 27) of "The Homeland Handbooks"—"Lynton, Lynmouth, and the Lorna Doone Country." London: The Homeland Association.

(b) Consult Messrs. Ward, Lock and Co.'s "Pictorial and Descriptive Guide to Lynton, Lynmouth, and North-East Devon."

As internal treatment, M. Ruault recommended benzoate of soda (one drachm for children and twice that amount for adults, in divided doses during the day). This drug arrested the progress of the coryza or abridged its duration. Other agents, such as tincture of belladonna, aconite, or opium, were advised by different authors, but their action was uncertain.

The local means should be preferred. At the first sneeze, inhalation of the vapour of eau de Cologne, so as to produce a sensation of heat in the pituitary membrane, is very beneficial. A few drops of the following solution, on blotting paper and inhaled, also act well:—

R. Phenic acid, 5 ;  
Ammonia liq., 5 ;  
Proof spirit, 1 ;  
Water, 1.

Some rhinologists refuse to prescribe injections of the nares in the acute stage of coryza, contenting themselves with spraying the parts with a warm solution of cocaine at 1-100, or adrenalin 1-1,000. M. Courtade, however, irrigates with a saline or boric acid solution at a very high temperature (118°), which he repeats morning and evening, using a pint at a time. According to him, one or two days suffice to effect a cure if the treatment is begun at the very outset of the attack, the first or second day. If later, the chances of success are diminished; nevertheless the gravity and duration of the malady are always attenuated. M. Courtade prescribes at the same time, internally, salicylate of soda. This treatment would prevent the extension of the inflammation to the pharynx and the bronchi as so frequently happens in certain patients.

In infants, irrigations are impossible; they can be replaced by insufflations of air with an elastic ball, which expel the secretions; instillations of a few drops of a solution of menthol and olive oil (1-150) re-establish the permeability of the nasal fossæ.

#### A NOVEL METHOD OF SUTURING WOUNDS.

A practitioner is called to a case in a hurry without any indication of its nature; arriving at the house he finds himself in presence of a wound that requires to be sutured. He searches in his pocket for his emergency case, and finds he has left it at home. He has come perhaps a long way and does not want to waste time by returning to his house; he is annoyed. Going through his pockets again, he can only discover his little subcutaneous syringe. That is quite sufficient for the purpose, as Dr. Gerest, of St. Etienne, points out, and he will proceed to suture the wound in the following manner:—

Opening the inside lid of the little case, a bundle of silver wires for keeping the needle patent is found. He takes one of these wires and inserts it into the needle, taking care that it does not project beyond the point. He then passes the needle through both edges of the wound; pushing the wire a little beyond the point he holds it while he withdraws the needle. It is thus by this simple method that the suture is through and ready to be twisted. The same operation is done as many times as sutures are needed, and then the edges are drawn together.

The advantage of this simple method over the ordinary operation is that it is much less painful. There is no dragging on the needle loaded with a double thread which is so much dreaded by the patient.

Naturally, the above method can only be applied to simple cutaneous wounds, but do they not form the majority of minor accidents?

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 26th, 1904.

### A MODERN VIEW OF THE ETIOLOGY, PROPHYLAXIS, TREATMENT AND PROGNOSIS OF PULMONARY PHTHISIS.

THIS subject is discussed by Dr. Farnowski in a recent number of the *Prager Med. Wochenschr.* The author believes that pulmonary tuberculosis arises from inactivity and that, therefore, it can be removed by work. He recognises the lymphogenous origin of the disease, the commencement of which lies in the earliest youth. One finds the lymph glands swollen and pleuritic rubbings are often heard. The low power of movement of the apices explain why these parts are the first to be attacked. The prophylaxis consists in the most careful attention to the nose, mouth and fauces, whilst the breathing should be exclusively nasal. All tuberculous subjects with bronchial symptoms should be kept away from children; mothers who are diseased should be forbidden to suckle and nurse their children, and such should be warned against allowing conception to take place. Two symptoms are mentioned as specially characteristic of the early stage: a peculiar, tormenting, burning pain between the shoulder-blades, especially when the body is bent forwards, and a disagreeable sweat odour, often noticed when the clothes are being taken off. The most important therapeutic agent is respiratory gymnastics. As, however, the author does not trust to the exercises being carried out properly, he orders inhalations to be made several times a day of vapour with a medicinal addition. These should act as regards the lung exercise as object lessons from an educational point of view, and also as expectorants. Patients with hæmorrhagic expectoration or pronounced hæmoptysis should not, of course, practise these exercises. In suitable neighbourhoods the terrain treatment is carried out, nasal respiration being indispensable. For inhalation, the prescription following is made use of:—

R. Guaiacoli purissimi.  
Iodipin.

Liquor. sod. sulphiti ana 5 grm.; ft. emulsio.  
S. 1 to 15 drops to be inhaled thrice daily.

The commencing dose was one drop, the length of time and the increase of dose being decided by the condition of patient. The chief aim is the lung exercise, the action of the drug only secondary. Deep nasal inspiration alone had an anticatarrhal influence. With the idea of preventing a fresh invasion of tubercle bacilli, the author orders nasal douching and very thorough cleansing of the teeth with subsequent washing out of the mouth and gargling. Anæmia, one of the most frequent complications of tuberculosis and nervousness, he treats with the same cure. Disturbances of the digestive tract must also be treated; loss of appetite is frequently overcome by solveol, guaiacol, or creosotal. The patient's prospects are improved by careful attention to all the details given. He does not look upon pulmonary tuberculosis as cured when bacilli are no longer to be found in the sputum, but when normal breath sounds are heard again in the chest, when pleuritic rubs and bronchitic symptoms have disappeared, and the lungs have regained their normal elasticity. He looks upon people in the first and second stage of the disease as fit for work, and allows them to work during the time of treatment. He only allows them to announce themselves ill from time to time for purposes

of rest and recruiting from work, by which the treatment is assisted. He looks upon people's curative establishments as without any object, their value lying only in their being places of refuge for the incurable, and as diminishing the chances of infection of others. He also considers treatment in high altitudes as unnecessary, as bronchitis may be prevented by nasal breathing and protection from cold. Finally, he lays the greatest stress on the utmost dexterity and expertness with the stethoscope, whereby the ear becomes familiar with all the sounds of the borderland between the diseased and the normal. He would rather trust the ear than the microscope.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 25th, 1904.

#### FALSE LEGS OF IRON.

At the Naturforscher meeting, Hovorka showed a prosthesis which, he said, had all the advantages of lightness and cheapness that the present age of economy could desire, more particularly in warfare, where so many limbs were mutilated. It was in its simplicity a very light steel tube finished with gauze, which acted as the upholstery for the fitting. He thought the amputating surgeon should work with the instrument-makers in these prostheses, when an operation was performed, as they assisted him to secure by mechanics the greatest utility of the limb, which added greatly to the advantage of the patient's usefulness in after life. There is one small matter in the treatment which should not be omitted. The stump usually atrophies and contracts for some time after the operation. To hasten this action massage should be practised zealously to hasten and harden it for the prosthesis.

#### INCARCERATED HERNIA.

Haberer related the history of a few cases of bowel torsion and incarceration which he had operated on. The first was a hernia associated with purulent peritonitis, which died. The second was torn in replacing the bowel and caused profuse bleeding. The wound was sewn up, the whole cavity washed out, and the bowel returned with a successful issue.

Plucker related a case of hernia which he treated that occurred in the seventh intercostal space after a stab with a sharp instrument which had evidently pierced the diaphragm, allowing the peritoneum and bowel to escape into the chest. Resection of the eighth rib was performed and the whole of the prolapsed bowel replaced after relieving the perforation of the diaphragm, which had strangulated the hernia.

After closing the wound with a few stitches, a tampon was placed over the rupture to hold all in place, but, unhappily, empyema set in and complicated the case, which finally healed up and made an excellent recovery.

Hippel thought that these were very uncertain cases to deal with, as the protrusion of the peritoneum and part of the bowel was no guarantee that other parts of the internal organism were not injured, though the protruding parts were perfectly free and healthy.

Plucker said that a distinction ought to be made between wounding the diaphragm from the abdomen and wounding it from the thorax. In the former case, laparotomy would be the correct method. Again, if the instrument were long and pointed, even when penetrating from the chest, laparotomy should be the operation to follow, but the judgment of the surgeon must be the guide.

Braun then related a few cases of occlusion of the colon from displacement and torsion.

Rhen said that he had only seen one of colon occlusion from torsion and one from displacement of the cæcum, in the case of a girl going to school, and falling on the ice. The great effort to prevent the fall displaced the bowel, and quite closed the lumen. Both cases recovered after the operation.

Hoffmann at this juncture related a peculiar case of laparotomy, which he performed for partial peritonitis, with a supposed purulent abscess according to diagnosis. On opening the abdomen the stomach was distended with five or six litres of brown fluid, resembling that previously vomited. The pylorus was quite free and would permit two fingers to pass. During the operation the patient collapsed. In the post-mortem the pancreas was found necrosed, while all the other organs were healthy.

How this acute dilatation of the stomach occurred was somewhat puzzling. Hoffmann could see nothing to account for it but the sudden loss of atony with a greater amount of distention than usual.

Wohlgemuth related another case of abdominal complexity, where he operated for appendicitis or cryptorchism. Both diagnoses were correctly made. Laparotomy revealed a compromise. Cryptorchism was present with genuine ulceration in the appendix.

#### SURGERY IN JACKSON'S EPILEPSY.

Berge recorded two cases of Jackson's epilepsy on which he operated, the first being six years after the accident to the head. There was a slight impression of the wound still existing on the left parietal bone on the left side, which he raised and found a few sharp spikes underneath, penetrating the grey substance, and along with this a cyst. After removal the fits disappeared, but the paralysis of the right hand and right leg still persisted. The second case was that of a young girl, æt. 13, with a cyst on the floor of the right lateral ventricle. He finally covered the wound with a König flap, which healed perfectly. In a fourth case he could not obtain the same successful result. The epilepsy disappeared all right, but the paralysis still continued after the probable extirpation of the centre, which lies about 1½ centimetre below the surface. After discussing the theory of Jackson's disease, he reviewed the treatment adopted by Jonnescus by extirpating the cervical sympathetic gland on both sides of the neck with the object of reducing the blood pressure in the brain.

#### TO PREVENT URINARY INFECTION.

Goldberg gave the results of his experiments with strepto- and staphylococci, as well as with coli bacilli. This form of treatment was successful in 88 per cent. of the cases where stone was located in the bladder, while eleven were improved. In the case of stricture, 92 per cent. were successful and eight failed; in 78 prostate cases 75 were not infected; in 28 retention cases only three failed; and from 56 infected cases 25 were perfectly healed by the application, and 31 improved.

#### THE SURGERY OF CHRONIC NEPHRITIS.

Stern related the case of an eight-day anuria in which he had operated for calculi in the kidneys, but on reaching the organ he found it to be a case of chronic nephritis on both sides. Two hours after the operation a large quantity of urine was passed, but subsequently the patient died. The post-mortem confirmed the diagnosis of chronic nephritis on both sides.

In another case he tried Edebold's method of decapsulating, but without success. In one of nephralgia he adopted Isreal's method of splitting the enormously distended capsule, which gave immediate relief. The same good result followed the operation in a case of

hæmaturia without any stone as a cause. He is prepared to substantiate Isreal in his opinion of doing good by surgery in these cases.

Rehn advocated great care and caution in the selection of cases for nephrotomy. He had performed the operation in several cases of renal hæmaturia, but lost every one of them. He believed the operation only aggravated hæmorrhage, as the patients always got worse after.

## The Operating Theatres.

### GUY'S HOSPITAL.

**OPERATION FOR CANCER OF THE STOMACH.**—Mr. ARBUTHNOT LANE operated on a woman, æt. 64, who had a tumour in her epigastrium, and suffered from constant vomiting when any food was taken, the stomach being able only to retain temporarily a very small quantity of fluid. Manual examination suggested an old-standing growth of the stomach, apparently about its centre, and involving a considerable area of the organ. A vertical incision was made, and the stomach exposed. An extensive growth occupied in an annular fashion the middle third of the viscus. As far as could be made out, no gas could be driven from the small portion of the remainder of the cardiac end, which was free into the portion of the stomach beyond the growth. Indeed, the patient had been kept alive with nutrient enemata for a considerable time. The upper part of the jejunum was divided and the distal section connected with the cardiac portion of the stomach. The proximal part of the jejunum was then put into the distal portion of the same gut at a convenient distance from its communication with the stomach. Considerable difficulty was experienced in effecting the connection with the stomach because of the smallness of the area of the cardiac end unaffected by growth, and because of its fixation. Mr. Lane pointed out that the period in the course of the disease in which the operation was performed rendered any attempt at partial or complete excision of the stomach impossible, as the growth was so extensive, and besides there was much glandular infiltration; still the procedure adopted, he thought, would render the remainder of the patient's life less miserable than it had been previous to operation. Mr. Lane considered that this method was certainly accompanied by much less risk and discomfort to the patient than the older manner of operating, while at the same time it was performed with great ease. By means of this operation, he said, any regurgitation of food from the small intestine into the stomach is avoided, and the risk of kinking is *nil*. He also preferred to establish the junctions without any mechanical aid whatever.

**OPERATION FOR THE EFFECTS OF CHRONIC CONSTIPATION.**—The same surgeon operated on a woman, æt. 35, whose recent life had been a burden to her from the pain and discomfort she experienced in consequence of chronic constipation. Besides the appearance of premature senility, which, Mr. Lane pointed out, was always a consequence of the auto-intoxication present in these cases, she had the usual local pain below the last rib on the right side, the tenderness and fulness in the right iliac fossa, frequently accompanied by a fulness in the pelvic region, with pain and discomfort in the vicinity of the sacrum, and in addition all the other symptoms found in this

condition. An opening was made in the left groin through which the transverse colon immediately prolapsed. Mr. Lane drew attention to the fact that in these cases the transverse colon forms a U with its convexity downwards, frequently reaching into the pelvis. The whole of the true pelvis was occupied by the distended cæcum, the end of the ileum entering it to the left of the rectum; the sigmoid flexure was so shortened up and bound down by the adhesions which had formed about it that it would have been unwise, Mr. Lane said, to attempt to utilise it; fortunately, as is usually the case, the rectum was much dilated and elongated, and its walls were considerably hypertrophied. The ileum was cut through about six inches from its termination, between a couple of encircling ligatures; the ligatured stumps of bowel were then inverted by purse-string sutures, which passed through the peritoneum and muscle at a suitable distance from the ligature; the proximal end of the ileum was then connected laterally with the rectum, an aperture of communication of considerable size being effected. Mr. Lane said that the risks of the operation are much reduced by prepurgation and previous frequent irrigation of the colon by some suitable antiseptic lotion. Mr. Lane remarked that the results of these operations for the condition consequent on a habitual overloading of the cesspool have proved at least as satisfactory as he had anticipated. The risk associated with the operation he considered to be very small, whilst the benefit the patients derived both in comfort and in the condition of their nutrition is remarkable. The subsequent progress of the case was most satisfactory.

**OPERATION FOR BADLY UNITED FRACTURE.**—The same surgeon operated on a man, æt. 40, for complete physical disability which was consequent upon a spiral fracture of the right tibia and fibula, the disability being caused by a considerable overlapping of the bones, which were connected together by a quantity of callus, which occupied the interval between them. Owing to the alteration in the axes of the fragments to one another, the patient was unable to walk securely. An incision was made over the tibial junction, and the seat of the fracture freely exposed. The axes of the fragments were accurately defined, and sections were made through each at an angle of 45° in such a manner that the tibial surfaces could be brought accurately together after the bone intervening between the two sections had been removed. The surfaces were brought into accurate apposition, and were retained immovably by a couple of stout silver wires, which passed through the extremities of both fragments. By means of this operation, Mr. Lane said, the axes of the fragments were rendered identical.

### St. Vincent's Hospital, Dublin.

We have been asked to state that the Inaugural Address which was announced to be delivered at the opening of the winter session of the above hospital, on Tuesday, October 4th, has been unavoidably postponed until Tuesday, October 11th.

### Apothecaries' Hall of Ireland.

THE quarterly examinations will take place on the following dates in October:—The first professional will commence on Monday, October 17th, 1904. The second professional, on Thursday, October 20th; the third professional, on Monday, October 24th. All entries must be lodged at least fourteen days previously with the Registrar, 40 Mary Street.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, SEPTEMBER 28, 1904.

**ORAL INFECTION.**

ONE of the recent developments of Listerian principles is to be found in the increased attention paid not only by dentists but also by general surgeons to infective conditions of the mouth. It is, of course, obvious that the mouth can never be made, even if it were desirable to make it, absolutely aseptic. The buccal cavity is possessed of its normal flora just as the skin and intestines are; no amount of care and no expenditure of antiseptics can ever render any of them sterile. In the case of the mouth several pathogenic organisms are so commonly present that in judging their significance one has to reckon rather with their numbers and virulence than with their actual presence. It is precisely on account of these bacteria finding a normal *habitat* in the mouth that minor conditions of disease and injury of the buccal tissues constitute a menace disproportionate to their actual extent. The interest that is now being taken in the subject is evidenced by the fact that oral infection formed a subject of debate this summer at both the British Medical Association meeting and at the annual session of the American Medical Association, and that large numbers of surgeons put in an appearance in the respective dental sections of those meetings to take part in the discussions. Diseases of the teeth and contiguous structures are apt to be regarded by medical men as belonging too exclusively to the province of the dentist, but it should not be overlooked that although much of the treatment may have to be carried out by the latter, the responsibility of making the primary diagnosis usually falls on the general practitioner. For he it is whom the patient first consults, and his will be the delicate task of deciding whether the condition of the mouth is secondary to some disease of the whole system, or whether the buccal affection is the

primary cause of the constitutional symptoms. The blood supply of the gums and dental pulp is a terminal one, situated at some distance from the centre of the circulation, so that it is not surprising that in states of impaired or perverted nutrition these structures are some of the first to suffer. With their resistance thus lowered, the teeth and gums become a ready prey to the pyogenic organisms of the mouth, and the interesting condition now known as pyorrhœa alveolaris is a not infrequent sequela. The differentiation of this affection from an ordinary alveolar abscess is most important, as not merely is the dental procedure required for its cure totally different, but the general ill-health at the root of the trouble calls for special treatment according to its nature. Moreover, if the practitioner is on his guard he will perhaps be able to avert the onset of pyorrhœa alveolaris if he includes in his directions to the patient instructions as to the proper cleansing and rubbing of the teeth. When pyorrhœa alveolaris has already set in, the sufferer should be placed as soon as possible in the hands of a scientific dentist so that all tartar and concretions about the teeth may be removed, and the whole visible surface polished and thoroughly cleansed. By this means, combined with continued local lavage and general constitutional treatment, the patient will be placed in the best circumstances for bringing about a cure of this troublesome disease. Although it is pyorrhœa alveolaris following some general affection that comes most frequently to medical notice, there are still other general affections which result from pyorrhœa alveolaris of purely local origin. These affections generally assume the form that it is fashionable at the present day to call auto-intoxication, and pyorrhœa alveolaris set up by neglect of the teeth or by accidental circumstances may gravely undermine the vitality of the whole system by continually pouring into the mouth morbid discharges of a purulent character. The persistent absorption of the bacterial toxins contained in such discharges cannot but be baneful, and it is more than probable that local derangements of the throat and stomach are also caused by this action. Dr. Rhein, whose paper introduced the discussion in the Section of Stomatology at the Session of the American Medical Association this year, made a very suggestive point in connection with the evil of oral infection. He animadverted on the strange anomaly that the strictest asepticism is secured in all surgical appliances during an operation, and that every part of the patient in the neighbourhood of the wound is rigorously treated with disinfectants, whilst the mouth is entirely overlooked as a possible source of infection. Not only ought it to be impossible for secretions of the surgeon's and his assistants' mouths to contaminate the wound—an event guarded against in some hospitals by the wearing of respirators—but in operations on the alimentary tract the patient's own mouth ought to be considered as a potential source of danger, and brought into a condition of the greatest possible cleanliness. Almost precisely similar remarks



were made by Mr. Godlee at the British Medical Association meeting, whilst he further pointed out the improvements in the results of operations on the mouth due to the greater care expended on securing oral cleanliness. The dangers of infection from unhealthy conditions of the mouth cannot be too seriously pondered over, and watched for, by medical men.

#### THE SEIZURE OF TUBERCULOUS MEAT.

THE development of a systematic study of the comparative pathology of tuberculosis shows that we have still much to learn regarding the nature of that disease. It is also becoming clear that the dogmatic assertions of many alarmists are not in accordance with scientific fact or homely common sense. We are glad, therefore, to receive rational direction even from such a conservative body as the Local Government Board. The Board has considered the Report of the Select Committee of the House of Commons on the Tuberculosis (Animals) Compensation Bill of this year, wherein reference is made to the variety of practice existing with regard to the amount of tuberculous deposit in a carcase held to justify its total condemnation. They have also considered the complaints made by butchers as to the injury caused by their prosecution in open court for having tuberculous meat upon their premises. An official circular has now been sent out to the Councils of Metropolitan and other Boroughs and of Urban and Rural districts. Speaking generally, it is most desirable that there should be as far as possible uniformity in the practice of meat inspection. The principles laid down by the Royal Commission on Tuberculosis in 1898 furnish rational and trustworthy directions. The entire carcase and all the organs might be seized when there is miliary tuberculosis of both lungs, when tuberculous lesions are present in the pleura and peritoneum, when tuberculous lesions are present in the muscular system, or in the lymphatic glands, embedded in or between the muscles, and when tuberculous lesions exist in any part of an emaciated carcase. If otherwise healthy the carcase shall not be condemned, but every part of it containing tuberculous lesions shall be seized when the lesions are confined to the lungs and the thoracic lymphatic glands, when the lesions are confined to the liver or pharyngeal lymphatic glands or any combination of the foregoing, but are collectively small in extent. We are pleased to find that the Board are of opinion that at the present time there is no need for any further increase in stringency, but they very rightly insist on the importance of action in strict accordance with the principles which have been laid down. It is also a judicious instruction that if a butcher who is in possession of tuberculous meat has notified the fact to the proper authority as soon as he could be reasonably expected to be aware of it, the case should not be taken into court. We are certainly not a logical people, and as a nation our scientific instincts are not notable, but in dealing with morbid conditions generally, Englishmen may

usually be counted on as willing to adopt and comply with any reasonable directions based upon established scientific facts. We may congratulate ourselves that the "medical advisers" to the Local Government Board are at least free from the all too prevalent phobia regarding the dangers of tuberculosis.

#### INFANTILE DIARRHŒA.

THE important subject of the relation of infantile diarrhœa to public health has received concise and practical treatment at the hands of Sir Charles Cameron, the Medical Officer of Health of Dublin, in a recent report to his Public Health Committee. The disease is one which is increasing year by year in our large cities, and under modern conditions is likely to go on increasing, unless strong measures are taken to prevent its spread. In America it has proved during the last half decade such a veritable scourge that its prophylaxis and treatment are regarded as one of the most serious problems that confront the sanitarian. In these countries, partly owing to difference of climate, and partly to different customs of nursing, it has not yet become so widespread, and consequently has not received the attention it deserves. The rates of mortality quoted by Sir Charles Cameron, however, show that it can no longer be neglected, and that it is tending to become the cause of a large proportion of deaths occurring in young children. In Dublin the death-rate from this cause is comparatively low, in no week rising above 5.5 per 1,000 living, though when we remember that infantile diarrhœa is a preventable disease, this still represents an appalling waste of life. In other cities—Liverpool, York, Hull, Salford, Walsall—it is much higher, reaching the highest point of 16 per 1,000 in East Ham. Without going into the question of the bacterial causes at work, a subject which is being thoroughly investigated in the States, there is no doubt that practically speaking, unsuitable food is responsible for infantile diarrhœa. Among the cases whose history Sir Charles Cameron was able to investigate, out of seventy-four infants under one year old who died from this cause, only eleven were at the breast. Of twenty-five children over one year old, nineteen took ill after the nursing by their mothers had ceased. As nursing at the breast is the rule in Dublin, and feeding by the bottle the exception, it will be seen that the incidence of diarrhœa on those who are bottle-fed is enormously greater than on breast-fed children. The higher rates we have mentioned as occurring in some of the larger English cities are probably due to the greater frequency of bottle-feeding in them than in Dublin. The bottles are rarely kept clean, and when rubber tubes are attached, they are usually simply culture-fields of bacteria. When not in use, the bottle is commonly laid on the window-sill and exposed to street-dust, but not infrequently its resting-place is the even more insanitary coal-hole, dirty cupboard, or hob. In many cases the milk with which infants have been fed has been kept from the previous day,

and of course in impure surroundings. In addition to milk it is extraordinary what things mothers give their young children as food. Sir Charles Cameron's list for infants under a year old includes cabbage, potatoes, fruit, meat, fish, bread, rusks, and various artificial foods, while he notes the not uncommon habit of administering porter as a sedative. It is to be remembered that this system of dirty and bad feeding is in nearly every case the result of sheer ignorance, and but rarely due to a criminal carelessness. The mother does not intend to injure the child—she merely feeds it, as perhaps she herself was fed, and as her neighbours feed theirs. She, indeed, finds it hard to believe that the child's illness is due to any preventable cause, and she is astonished and insulted at the suggestion that the food is bad or the bottle dirty. It is here that much good can be done by education. Instruction in elementary hygiene should be given in the primary schools, for the Board-school pupil of to-day is the parent of a few years hence. And indeed, instruction has very often a wonderful way of filtering through the children to the elders at home. The employment of intelligent female visitors to the houses of the poor can also do much good, but they must have tact, or their advice will be worse than futile. Perhaps one of the most pregnant suggestions ever made with regard to the etiology of summer diarrhoea was that of Dr. F. J. Waldo in his Milroy Lecture some years ago. He surmised that the peculiar incidence of the malady in towns might be explained by food contamination by dust charged with the bowel organisms of lower animals, especially the horse. There is, perhaps, no disease whose prevention is more completely in our hands than infantile diarrhoea, and the responsibility is with our sanitary authorities to make it, as a cause of death, a vanishing quantity.

### Notes on Current Topics.

#### The Weekly National Bill of Health.

THE weekly returns of births and deaths in London and seventy-five other great towns of England and Wales are fountains of perennial interest. The total deaths registered for the week ending September 17th corresponded to an annual rate of 17.0 per 1,000 of their aggregate population. A rate of 17.0 represents a good average, although far above the standard ideal aimed at by zealous sanitarians. In the preceding three weeks the rates had been 20.5, 18.2, and 17.5. The highest annual death-rate per 1,000 living, as measured by last week's mortality, were from all causes, 25.1 in Hull, 25.5 in Sunderland, 26.1 in Hanley, 27.8 in Salford, and 31.6 in Wigan. The fallacy of taking a single week, however, is shown by taking a town like Liverpool, where the mortality for the four last weeks has been 29.4, 27.2, 24.7, 22.3; and in Bootle, with 30.4, 28.7, 23.6, 17.7. Sunderland, on the other hand, has been 19.3, 19.7, 18.3, 25.5. Hull has been fairly consistent with 26.5, 26.3,

21.2, and 25.1; Wigan, 31.6, 25.7, 29.9, and 31.6; while Salford has returned 33.5, 26.6, 23.7, 27.8. Preston, which formerly had a bad record, showed 19.5, 22.2, 21.3, and 19.0. One death was reported from small-pox in the provinces and one in Glasgow. A large number of deaths were due to diarrhoea. In London the mean average of patients in the infectious hospitals during the past thirteen weeks was: small-pox, 38; scarlet fever, 1,753; diphtheria, 771; and enteric fever, 93.

#### Pharmacy Law in the Transvaal.

THE Transvaal Pharmacy Ordinance, which last month became law, by the assent of Lord Milner, contains several points which are distinctly in advance of the position of pharmacy law in these countries. In reference to the much-vexed question of company proprietorship of druggists' shops it is provided that the managing director of the company shall be in all cases himself a registered "chemist and druggist," and that the name of the assistant managing the shop or branch shall be posted in a prominent place in the shop. Even more stringent is the regulation that for an offence committed by a company every director shall be responsible, just as if the offence were committed by him as an individual. This, we understand, is a reform for which the Pharmaceutical Society at home is striving. As regards the sale of poisons strict rules are to be enforced. A penalty of a fine up to seventy-five pounds, or six months' imprisonment, is named for the offence of keeping or selling poisons without labelling them "poison," while lesser fines or terms of imprisonment are named for other offences. We think the power to send to prison in these cases is a very useful one, and we should be glad to see clauses embodying it added, not merely to our own pharmacy laws, but to the licensing laws in general.

#### Lesions in Movable Kidneys.

ABNORMAL mobility of any organ of the body does not in itself constitute a disease, though it is quite common to find that such increased freedom of movement or, it may be, actual displacement induces reflexly a train of symptoms which may be productive of life-long suffering. In the case of the pelvic viscera this is especially noticeable. The liability of an unduly mobile or misplaced organ to disease has many times been discussed, but clinical evidence would seem to prove that it is not more likely to undergo structural change than one which is normally in position, unless adhesions are contracted between itself and the neighbouring tissues. With regard to the kidneys, it is frequently observed that alterations in their position are found in neurotic subjects, though the reason for this is not quite obvious. The association of a movable or floating kidney with gall-stones is well known, and displacement or ptosis of other organs may be present at the same time. Kinking of the ureter occurs sometimes, but with less frequency than might be supposed. Intermittent hydronephrosis should, therefore, be a common

occurrence in cases of considerable mobility, and this would eventually lead to degenerative changes in the kidney itself. In a series of cases in which the operation of nephropexy was performed at the Chelsea Hospital for Women, Mr. Frank E. Taylor (a) has found that unsuspected lesions were discovered in no less than 10 per cent. Three cases are reported, in two of which the misplaced organ contained a calculus, while the third proved to be one of renal tuberculosis. Two other cases are also described in which the organ was hydro-nephrotic as well as movable. The inference to be drawn from these observations is that the kidney should be carefully examined at the time of operation, special attention being paid to any doubtful-looking spots.

#### A Medical Journalist.

THE brilliant journalistic feat of Dr. G. E. Morrison in securing for the *Times* the full text of the new treaty with Tibet, about which so much mystery hung, brings into prominence again the name of one of the members of the medical profession who have found fame in other fields than that for which they were designed. Born under the prosaic roof of Geelong College near Melbourne, the spirit of adventure early seized Morrison, and he first distinguished himself by voyaging in a canoe the whole length of the River Murray, which is to Australia what the Mississippi is to America. Not content with this, he next walked across the Australian continent from north to south, writing an account of his wanderings for the *Melbourne Age*. The same paper sent him on a voyage in a trading schooner among the Pacific Islands, and subsequently to New Guinea as leader of an exploring expedition. There his career nearly came to an end for he was badly wounded by a native spear; in fact, part of the weapon remained in his body for many months and was only finally extracted at Edinburgh, whither he had gone to study medicine. After graduation, Dr. Morrison started off on his travels, once more finding his way to the Rio Tinto mines in Spain, where he officiated as medical officer, and to Ballarat, where he was appointed the superintendent of the district hospital. It was, however, at Pekin as Special Correspondent to the *Times* that he found his *metier*, and few will forget his well-informed and prescient telegrams on the events preceding the Boxer rising. Lord Curzon, then Under-Secretary for Foreign Affairs, had finally to confess that the *Times* was better informed than the Government. Medicine seldom leads its followers to fame as journalists, but so long as it possesses in its ranks men of the type of Dr. Morrison, it will have no cause to be ashamed of its performances in this respect.

#### Moral Imbecility.

THE condition to which the term moral imbecility has been applied should be understood and recognised by all teachers and trainers of the young, for thus only can its unfortunate subjects be pre-

vented from disgracing themselves and doing injury to others. Medical treatment is not likely to be of any use, but an early diagnosis may be the means of enabling the guardians of a child to deal firmly and wisely with him. A shocking case of a moral imbecile occurred recently in America. The subject was a sick nurse, aged forty-five, and when she was finally brought to book it was found that she had fatally poisoned some twenty people, besides having attempted arson on several occasions. Her favourite plan was to administer the lethal drug in Hunyadi János water, but sometimes she did so by enema—always, however, so combining the poison with other drugs that its characteristic effects were masked. She was not the subject of any delusions or fancied injury, but appeared to be actuated by a sheer reckless love of destruction. It came out that her father had been eccentric in his habits, whilst one of her sisters was a chronic dement and another a prostitute. She herself had been a troublesome child, given to lying and deceit, and though entered at two-training schools as a nurse she had been dismissed from both. Her lying propensities had been recognised at these institutions, and she was regarded as untrustworthy in character and peculiar in manner. Under the circumstances it is little less than astonishing that she should have found employment as a private nurse, but such was the case, and the disastrous result already mentioned followed. At her trial a commission of three medical men was appointed to inquire into the state of her mind, and they had no difficulty in finding that she was not responsible for her actions. She was removed to a State hospital for care and restraint, and within a year developed delusions of poisoning and hallucinations of hearing, accompanied by marked impairment of initiative. That a woman of this kind should have been allowed to continue for years in the enjoyment of public confidence in a civilised country is barely credible, and we think her career forms an argument for the State regulation of nurses, both in this country and America, although under any system the difficulty of detecting the early stages of mental disease and irresponsibility would obviously remain.

#### Bechterew's Reflex.

A NEW reflex promising some aid in the diagnosis of lesions of the spinal cord is described by Bechterew, (a) and its presence and significance are corroborated by the fact that they have been independently discovered and described by another physician, Mendel. This reflex is somewhat analogous to Babinski's, and can sometimes be obtained when the latter is uncertain or altogether absent. Bechterew's sign is elicited by striking lightly over the dorsum of the foot at the base of the toes, when immediate flexion of the digits follows in certain pathological conditions. If the sign is well marked, there may be also abduction of the toes, but the essential feature is the flexion. It does not occur in perfectly healthy persons, but only when an organic lesion of the pyramidal tracts of

(a) *Annals of Surgery*, August, 1904.

(a) *Obozrenie Psichiatii*, June 1904.

the cord is present, so that its significance is much the same as that of Babinski's sign. In some cases a similar reflex can be elicited, according to Bechterew, in the hand, percussion over the carpo-metacarpal joints producing flexion of the fingers. While the difficulty of diagnosing organic from functional diseases of the nervous system continues to be so great, one is thankful for every little aid in clinical work, and if the new reflex is as trustworthy and helpful as that of Babinski has proved itself, it may be cordially invited to take its place in the category of physical signs.

#### Antiseptic Value of Iodoform.

THERE are few things so touching in recent practice as the love of the surgeon for iodoform. Far from being repelled by its odour he seems to positively revel in it, and as to reports from bacteriologists saying that it is neither aseptic in itself nor antiseptic when applied to wounds, he continues to regard such assertions as calumnies upon an old and valued friend. Enterprising firms bring out all sorts of elegant substitutes, but the surgeon passes them by unheedingly, and even occasional cases of iodoform poisoning do not deter him from scattering it freely on the next wound he encounters. After all, it seems, he is right. A reassuring paper on the subject has been published by Heile (*a*) as the result of some careful work he has done in the University Laboratory at Breslau. He found that iodoform under favourable conditions is broken up in the tissues, and that a body called di-iodoacetyliden—a powerful antiseptic—is given off. But for this action to be brought about the tissues must be allowed to act on the iodoform in the absence of air, when if the medium be alkaline the formation of di-iodoacetyliden goes on for a long time. Under such conditions an antiseptic value far higher than that of corrosive sublimate is attained by this new body, and thus it would seem that for once, at any rate, the clinical instinct of the surgeon has triumphed over the theories of bacteriologists. But it is important to notice that the formation of di-iodoacetyliden takes place only anaerobically, and therefore the sprinkling of open wounds with iodoform would not seem to be of much service. On the other hand Heile's researches, which we hope may be extended, supply a rational basis for the use of the iodoform gauze plug and drain to deep wounds, and it is satisfactory to know that this practice of the many eminent men who prefer iodoform gauze to any new product of the laboratory is apparently well founded.

#### The Cell and Immunity.

EVER since the disappearance of the old "exhaustion theory" of immunity, due in the first instance to Pasteur, two rival theories have contested the field, and it is only in these days that a final agreement between them seems possible. On the one hand there were those who held with Metchnikoff that the important factor in immunity

was the leucocyte, and that its so-called phagocytic function explained the facts sufficiently. On the other hand, Buchner and, in general, the German school held to a "humoral theory," believing that the protective bodies existed, not in the cells, but in the fluids of the body. Opposite and apparently irreconcilable as these two views were, Buchner made the first step towards uniting them by his expression of opinion in 1894, that the protective bodies—or alexins, as he termed them—although found in the fluids, were a secretion of the leucocytes. He regarded phagocytosis as of secondary importance. It, however, has been stoutly and consistently defended by Metchnikoff, and although at one time most inquirers other than those immediately influenced by him had ceased to attach much importance to it, it seems by the latest observations to have undergone a certain reinstatement. This has taken place as a result of the discovery by Wright and others of bodies called "opsonines," whose presence in the serum is necessary to enable leucocytes to exercise phagocytic powers. It is only, then, by a constant interaction of serum and cell that immunity is possible. On the one hand, the antitoxic and antibacterial bodies are in all probability secreted by the leucocytes and certain of the body-cells, while on the other, the phagocytic activity of the cell is only exercised in the presence of certain bodies supplied by the serum.

#### Private Hospitals.

ONE of the most noticeable changes in medical practice in our generation is the sudden and great growth of private hospitals. There is no doubt that in many forms of disease more suitable treatment and greater care can be given to a patient in a private hospital than is possible in his own home. In surgical cases, for instance, where operations are to be performed, they can be done with greater safety to the patient and much greater convenience to the surgeon in a room specially designed and kept for the purpose than in a hastily fitted bedroom in a private house. On the point of economy, too, the private hospital presents obvious advantages over the home. Instead of a patient requiring, as at home, the entire services of one or two nurses, a number of patients can be efficiently attended by one nurse. The cooking of food, too, and the preparation of invalid necessaries of every sort, is done as a matter of routine by those who are accustomed to it, while in a private house a sick person can often only receive due attention at the expense of the comfort of the entire household. Considering the many advantages on the side of the private hospital system we cannot wonder at its general adoption, and we may expect a still further extension in the future. With this increase, however, there will be considerable need of caution as to the management of many of the nursing homes which are likely to spring up. The custom which obtains in some homes at present of providing untrained women as nurses is strongly to be deprecated.

(a) *Archiv f. Klinische Chirurgie*, Vol. lxxi., p. 787.

There can be no objection to employing for some period of their probation pupils of a recognised training school in order to habituate them to the nature of private practice, but there is every objection to the permanent employment in these homes of women who have not gone through a regular course of training. Medical men should be very careful as to the qualifications of the nurses employed in the private hospitals they patronise.

#### Soap Tincture for the Hands.

It is probably true that success in sterilising the hands depends rather on the care shown by the individual surgeon than on the method employed. Nevertheless, as every surgeon wishes to make use of the method which is at once most efficacious and least troublesome, it is worth while drawing attention to the *rationale* of the action of alcoholic soap, which has been found successful by many. With the object of discovering the most serviceable antiseptic, Iverck has performed a series of experiments on moulds, and he believes that the best effects can be gained by a combination of watery and alcoholic germicidal solutions. He finds that spores, and probably bacteria, may be divided into two classes. The one kind is coated with a film of air, and is thereby protected against any watery poison, while the other, being coated with a mucous or gelatin capsule, is impervious to alcohol, but easily reached by water. The first part of the process of cleansing should, then, consist in the application of an alcoholic solution of soap, which effectively removes the air and emulsifies the fats of the skin, leaving the germs exposed. Rinsing in watery solution will then wash away or destroy the germs which have escaped.

#### The Artificial Production of Leukæmia.

AN important investigation bearing on the etiology of leukæmia was brought before the recent meeting of the British Medical Association by Dr. Moorhead, of Dublin. His report was only a preliminary one, and, consequently, tentative conclusions are alone permissible, but it is not too much to say that he has succeeded in producing in rabbits a condition bearing many resemblances to leukæmia. Having obtained a supply of lymph glands fresh from a fatal case of lymphatic leukæmia, several extracts, alcoholic, glycerine, and saline, were made. Of these one only, the saline extract, had any power. On infection into rabbits a marked fall of blood pressure took place, while continuous injection produced distinct changes in the blood-forming tissues. Controls with extracts of normal lymph-glands, and of thymus glands, were constantly negative. The principal changes produced by the leukæmia extract, which were remarkably similar in the three animals treated, were hyperplasia of the lymph-glands and spleen, leucocytosis, and softening and other changes in the bone marrow. The probability is that Dr. Moorhead has succeeded in obtaining a soluble toxin of leukæmia, and it is to be hoped that

further experiment on the same lines may succeed in elucidating the causation of one of the least understood of our common diseases.

#### The Management of Diphtheria Suspects.

IN spite of the great strides which sanitary science has made during the last couple of decades, the acute exanthemata do not seem much nearer extermination than formerly. Their virulence certainly seems to have undergone some modification, and that is the only noteworthy change in their life-history. It is a matter for congratulation that the medical profession are at last awakening to the futility of many of the methods which have received the sanction of authority and tradition for dealing with the acute specific fevers. The valuable papers by Drs. Biss, Millard, and others recently published in our columns have aroused an interest in the question which is the inevitable precursor of a thorough and systematic inquiry. There is one disease — diphtheria — so insidious in its onset that its presence may be wholly unsuspected. When this affection is epidemic there is always a considerable difficulty in determining the true clinical diagnosis in doubtful cases, and, in fact, the universal practice is to let the bacteriologist decide the question. Even when the report is in the negative, cases frequently occur in which the after-progress shows that the disease must have been one of true diphtheria. According to the annual report of the medical officer of health for Bristol, 1,134 cases were notified as diphtheria (including membranous croup) during 1903. Dr. D. S. Davies pointed out the great significance of the presence of the Hoffman bacillus in the nose and mouth of children who have been in direct association with cases of clinical diphtheria, and he considers that such scholars act as "carrier" cases. For such "suspects" the plan of opening an out-patient hospital, where the necessary local treatment has been applied by skilled nurses under medical supervision, has been found to work well. In this manner we learn that a more serious local outbreak was happily prevented.

#### "Breathing out Slaughter."

IF it be true that "many a true word is uttered in jest," it is equally certain that many of the quaintly-turned phrases and poetical ideas of the ancients contained such germs of truth as to place them on the level of prophecies. The expression, "breathing out slaughter," stripped of its poetic imagery and read in the light of modern bacteriology, becomes transformed into a bald statement of scientific fact. In other words, we are beginning to learn that the act of respiration is not quite so innocent as was formerly supposed, and that the air around us may be contaminated to a considerable degree by the organisms exhaled in the breath of every individual. Many of these bacteria are normal inhabitants of the mouth, and are non-pathogenic, but others may be the germs of specific

disease. With regard to the tubercle bacillus, the latest researches appear to show that the number of bacilli ejected in this manner in ordinary quiet respiration is so small that it may be disregarded, whereas the act of coughing is accompanied with danger to all around. The report recently issued by the Local Government Board devotes considerable space to the investigations undertaken by Dr. Mervyn Gordon into the contamination of air by various respiratory acts, such as coughing, singing and speaking. It has thus been ascertained that bacilli and streptococci are capable of being wafted to as great a distance as forty feet in front of a speaker, and the experiments of Nenninger are quoted to the effect that the *B. prodigiosus* may penetrate as far as the smaller bronchi of animals made to inhale the spray of an emulsion of this organism. This new phase of air-borne infection is worthy of consideration by those who have the interest of preventive medicine at heart.

#### The Incorporated Medical Practitioners' Association and the Midwives Act.

THE Council of the above body has at a recent meeting passed the following resolution regarding the action of the Central Midwives' Board in deciding to appoint unqualified women as examiners for the certificate of the Board:—"That we, the Council of the Incorporated Medical Practitioners' Association, at this our first meeting since the vacation, desire to place on record our protest against the action of the Central Midwives' Board in deciding to appoint as examiners for the certificate of the Board non-medical women, thereby raising to the level of the duly registered medical practitioner, who has undergone an expensive course of study and a searching examination, women who are not required to show proof that they possess any knowledge of the different subjects which a medical practitioner has to study in order to obtain a diploma." We thoroughly sympathise with this resolution and trust that other medical bodies in England and Wales will come forward and make a similar protest. The actions of the Central Midwives' Board since it commenced its existence have been in many instances apparently dictated by a spirit of opposition to the medical profession, and we regret to say that certain of the medical members of the Board have not made the firm stand against such actions that might have been reasonably expected.

THE forthcoming visit of French physicians and surgeons to London will take place from October 10th to 12th. It expresses in a particular form the general spirit of the *entente cordiale* between British and French citizens, and is therefore deserving of every encouragement at the hands of so loyal a body of citizens as the members of the medical profession. It is announced that the chairman of the Paris committee has written, stating that his party would probably include about fifteen professors of the Faculté de Paris, thirty physicians and surgeons of Paris hospitals,

seven teachers of provincial medical schools (lists on the table), fifty M.D.'s from various parts of France, and probably about thirty or forty internes, also that the party will be accompanied by twelve ladies. A number of hospitals and laboratories will be visited, as well as various workhouse infirmaries and Metropolitan Asylums Board hospitals. The entertainments include a luncheon provided by the *Lancet*, and a dinner held on October 12 at the Hotel Cecil.

#### PERSONAL.

INSPECTOR-GENERAL DUNCAN HILSTON, M.D., C.B. has been appointed Honorary Physician to the King in place of Inspector-General D. McEwan, deceased. Dr. Hilston, who joined the service in May, 1860, and retired in 1897, has seen active service in New Zealand when he was mentioned in despatches.

THE address at the opening of the Medical Faculty of the University of Birmingham will be delivered by Dr. P. H. Pye-Smith on October 3rd.

DR. J. N. McDOUGALL, of Coldingham, Berwickshire, was recently presented with a brougham by friends and patients.

THE opening address of the West London Post-Graduate College will be delivered on Thursday, October 13th, by the Bishop of Oxford.

MR. C. M. TUKE is the President for 1904-05 of the West London Medico-Chirurgical Society.

DR. GRAHAM BLICK has been appointed acting Resident Magistrate in charge of the Broome District, West Australia, and Chairman of the Broome Quarter Sessions.

ANY medical man resident in London who wishes to attend the dinner at the Hotel Cecil, to be given to the French physicians and surgeons on October 12th, should communicate with one of the Honorary Secretaries, Dr. Dawson Williams or Dr. W. Jobson Horne.

DR. LEITH NAPIER, of Adelaide, formerly one of the staff of the Chelsea Hospital for Women, has brought an action against the Government to recover £6,500 damages for fracture of the base of the skull sustained from a fall from a horse whilst serving on a contingent about to be dispatched to South Africa.

ON the occasion of their golden wedding, Dr. and Mrs. Latimer Parke, of Tideswell, Derbyshire, were last week presented with a handsome testimonial by residents of the Peak district, where Dr. Parke has been in practice for fifty-four years.

THE exhibition of the Institution of Hygiene in London will be opened by Sir Joseph Fayrer, K.C.S.I., on Friday next.

H. M. THE KING has been graciously pleased to confer the Volunteer Officers' Decoration upon the undermentioned officers of the Volunteer Force, who have been duly recommended for the same under the terms of the Royal Warrant, dated July 28th, 1892:— Surgeon-Major A. Lugard, 3rd Middlesex R.G.A.; Brigade-Surgeon Lieut.-Colonel W. D. Waterhouse, 4th V.B. Royal Fusiliers; Surgeon-Major E. Haydon, M.D., Hay Tor V.B. Devonshire Regiment; Surgeon-Lieut.-Colonel F. K. Pigott, 1st V.B. the King's Shropshire Light Infantry; Surgeon-Major J. G. Saville (retired), V.B. Manchester Regiment; Surgeon-Major W. L. Stewart, M.D., 1st Banff R.G.A.; Surgeon-Major R. Kerk, M.D., 8th V.B. Royal Scots; Brigade-Surgeon Lieut.-Colonel F. H. Appleby, 5th Notts V.B. the Sherwood Foresters.



**Special Correspondence.**

[FROM OUR OWN CORRESPONDENTS.]

**SCOTLAND.**

**NEW HOSPITALS IN GLASGOW.**—The hospital equipment of Glasgow has received an important addition by the opening of the new buildings at Hobhill, Duke Street, and Oakbank, which have been in course of erection for nearly four years. The buildings have been constructed by the Parish Council at a cost of nearly half a million, with the object of treating the sick and infirm poor separately from other paupers. The Hobhill Hospital has grounds to the extent of fifty-four acres, and is designed for the accommodation of 1,600 patients—the infirm poor, and children. The blocks containing the fourteen medical and surgical wards are built in two storeys each; the wards accommodate twenty-six patients in the main ward, and have side rooms for one or two beds in addition. There are also four two-storey blocks for the aged and infirm, isolation blocks containing four bed wards, and a children's section consisting of thirteen two-storey blocks, a school, and a building to accommodate 100 children likely to be in residence only a short time. Ample administrative buildings have also been provided. The Eastern District Hospital in Duke Street has accommodation for 200 patients, while provision has also been made for the treatment of about fifty mental cases. There are besides wards for medical, surgical, skin, and obstetric cases, isolation and observation wards, an operating theatre, mortuary, post-mortem room, and pathological laboratory. One special feature has been introduced—the radiation of wards from a common centre with the object, rendered necessary by the restricted space at the architect's disposal, of economising the ground occupied by corridors and staircases. The Western District Hospital comprises eight blocks, affording accommodation for 200 patients, and including administrative block and surgical, medical, maternity, and skin pavilions. Throughout the buildings there has been no attempt at ornament or decoration and the furnishing is of the plainest and simplest description. The policy of the Council has been, and wisely, to obtain the largest amount of accommodation at the smallest cost, along with all the most modern improvements and appliances for the benefit of the patients. The buildings were formally opened by Mr. George Dolt, chairman of the Council, on September 15th, and after the ceremony the party proceeded to Woodilee Asylum, another of the Council's undertakings, to inaugurate a new nurses' home, which has been necessitated by the increased number of nurses resulting from the introduction of female nursing into the male wards, and the handing over of the complete management of the sanatoria to women nurses.

**BELFAST.**

**SMALL-POX IN ULSTER.**—The outbreak of small-pox seems to be about at an end in Ulster. During the past week no new case has occurred except one in Monaghan, and as that was in a suspected family who had been under observation, and was at once isolated, it is not likely to be followed by others. The local authorities are now engaged in paying the bills incurred during the outbreak, not the least of which are those for vaccination, and from the remarks made at various public boards it is clear that if the payment of vaccination fees was not provided for by Act of Parliament the medical profession would fare badly.

**THE USE OF SALICYLIC ACID.**—An interesting case came before the Recorder of Belfast last week, in which the question at issue was the harmlessness or otherwise of the addition of salicylic acid to ginger wine, to the extent of 7.2 grains per pint. There was a great array of medical evidence, but, unfortunately, it was of that contradictory character which gives some excuse for the layman to scoff. The city analyst said that he believed salicylic acid to be a dangerous drug, which should only be used under medical advice. Dr.

Henry O'Neill said that the ordinary dose was 5 to 20 grains, and above this was dangerous. He gave a vivid picture of the state of collapse that might follow too large a dose. It was specially dangerous to persons suffering from diseases of the heart, liver, or kidneys, and in such its continued use might be followed by death. Dr. S. B. Coates agreed with Dr. O'Neill, and said he would not allow the smallest quantity of the drug to be used as a preservative in food. Dr. Torrens also corroborated this view, but went even further, for he stated that he had once been nearly killed by salicylic acid when he had rheumatic fever, and had never prescribed it since. Sir William Whitla said that though the B. P. dose was 5 to 20 grains, more was often given, frequently even as much as 120 grains a day. This would represent the amount contained in two gallons of the ginger wine, and the sugar in the same quantity, nearly half a stone, would, in his opinion, do more harm than the salicylic acid. The amount contained in the wine he considered absolutely harmless. All the bad effects described by the other witnesses were due to impurities in the drug, which used to be found almost constantly, but were absent now that better methods of preparation were employed. Dr. A. Montgomery was also examined, and expressed his agreement with Sir William Whitla. In summing up the Recorder said that if the drug was not necessary it should not be introduced into the wine, and if it were harmful it should not be introduced. As ginger wine had been used long before salicylic acid had come into use, and there was no evidence that it was better now than then, he was bound to conclude that it was not necessary, and therefore should not be introduced. It appears from this decision that the Recorder avoided giving any opinion on the question of the harmfulness or otherwise of the drug. We are not aware of any medical man who has a special weakness for ginger wine, but if any of us had, we should probably prefer it without the salicylic acid, so see no reason to regret the decision.

**Correspondence.**

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

**THE DIMINISHING BIRTH-RATE.***To the Editor of THE MEDICAL PRESS AND CIRCULAR.*

SIR,—Viewing this subject mainly from the same standpoint as Mr. L. W. Hudson, I agree with him that the discussion has been somewhat disappointing. It is especially disappointing to find Dr. Drysdale apparently retiring after contributing a letter full of controversial points and containing at least one dogmatic statement of the most questionable character. Dr. Drysdale has done more than any living Englishman to bring into practice the theoretical views he holds. Since the days of Mr. Bradlaugh and Mrs. Besant, whose colleague he was in the propaganda to which they devoted much of their lives, Dr. Drysdale has, if I mistake not, assumed the position of protagonist in this particular cult. Judging from his utterances he is probably proud to feel that thousands of married couples are acting upon the advice which he has persistently urged upon them. In some cases it is possible parents may be fully justified in limiting the number of their offspring; the danger lies in the creation of an overmastering sentiment of egoism throughout the nation, which may lead to what is practically race-suicide. It is in the influence upon a nation as a whole that I am most interested. Of this influence, when Dr. Drysdale's ideas are carried to their logical conclusion, we have a plain object-lesson in France. In view of this lesson, Dr. Drysdale has the hardihood to express the opinion that "Economically it is out of the question for the people of any European State like ours to think of having large families with impunity." Is he not bound to establish the truth of this statement by an examination of the

economical position of France in relation to the population question? France, with the most fertile soil—a soil capable of supporting many more millions than at present subsist upon it—the most magnificent climate, and the most intelligent populace of Europe, has not enough men for her home requirements. Her numbers are only kept partly up by immigration of Italians, Swiss, and Germans. She cannot spare, and virtually does not send, any emigrants to occupy and develop the vast possessions mis-named colonies—even to beautiful Algeria close to her shores—which she has acquired mostly within late years, so that these form in great part a useless burden, expense, and source of weakness to the State. France is already one-third less in population than Germany, and the disparity is rapidly increasing, so that resumption of her once dominant position in Europe seems for ever hopeless. It is not prudence alone which guides the modern French parent, but rather the narrowest form of anti-social egoism—the egoism which sacrifices everything in pursuit of ease and pleasure, and regards toil and self-abnegation as the sources merely of pain and unhappiness. These ideas are inculcated into the children—who among the well-to-do and wealthy are almost invariably guarded from the stress and fight in life, without which fine character can rarely be evolved. France is a dying nation through shrinkage of population, and she presents besides glaring signs of moral decay. These evils are only to be cured by abandonment of the vices of civilisation and a return to those more primitive, natural, and simpler customs which Dr. Drysdale is doing his best to banish from his own land.

I am, Sir, yours truly,  
A STUDENT OF SOCIOLOGY.

September 22nd, 1904.

#### THE LUNACY QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some years ago I was dining with the late Dr. Forbes Winslow in Manchester Square, when more than forty guests were present, and naturally the subject of insanity was discussed after dinner. The discussion assumed a very amusing character. Three pretty well-known men seemed to have put their heads together in a sportive mood—namely, Dr. Radcliffe, Dr. Clark, of the *Lancet*, and Mr. Ernest Hart. They were sitting nearly opposite to our hospitable host, and they seemed to be intent on provoking him by questions for the entertainment of the table. It ended in their doing this to such an extent as to make Dr. Winslow declare that in his opinion nearly all the world was insane. Of course, if that is really the view of any specialist in insanity, and if it is a correct view, we must find it rather difficult to know when to certify and how to deal with this subject in a moral and legal spirit. Professionally, however, I think we shall agree that when we have to do with a patient whose mind is diseased and who, in our opinion, is not capable of taking care of himself and may be dangerous to others, we ought, morally and professionally, to be careful and in no way be parties to any transactions which will not bear the just and proper criticism of an independent and capable lawyer, or of a jury of good men.

I am, Sir, yours truly,  
ROBERT LEE.

September 22nd, 1904.

#### Literature.

PATENT FOODS AND PATENT MEDICINES. (a)

THIS little book is composed of reprints of two

lectures given by Dr. Hutchison, that on Patent Foods being delivered before the South-West London Medical Society, the second being addressed to the students of the London Hospital. In the discourse on "Patent Foods," the author ingeniously defines a patent food as "a substance which is manufactured by artificial means from natural food products, and which is intended to be used as a substitute for ordinary natural foods, and . . . such foods are usually sold by pharmacists instead of being procurable from the ordinary dealers in common food." Dr. Hutchison then deals with the scientific considerations which might justify the manufacture of patent foods. Briefly, these are: where the patient has no relish for ordinary food, where difficulty in chewing or swallowing is experienced, when there is a necessity for predigested foods, where the physician desires to increase the amount of any particular ingredient in the diet, &c. Almost every artificial food in the market fails to meet the requirement of being reasonable in price, in comparison to the amount of nourishment obtained.

Dr. Hutchison says, "the majority of artificial foods do not correspond to any one of those qualifications I have set out." He goes on to show where they fail, and explains how even those that may be valuable because they contain certain desired constituents are very much more expensive and are no more satisfactory than certain ordinary foods or preparations that are not proprietary. For example, honey is much cheaper than extracts of malt, and contains wholly digested sugar, while that of the latter preparation is only partially digested. He also shows how seldom there is any necessity for predigested foods. Cod-liver oil emulsion, petroleum emulsion and pancreatic emulsion are shown to be practically unnecessary; the place for beef extracts is shown to be in the kitchen, and not in the sick room. Peptone preparations, beef juices, and many other foods are examined, and finally four pages are devoted to showing the composition of infants' foods.

The second lecture, one delivered to the students at the London Hospital, ought to be read extensively both by the medical profession and the general public. Its phraseology is such that the latter class can appreciate it as well as the medical man. Comparatively few people do not have recourse to patent medicines in one form or another, and we are immensely indebted to Dr. Hutchison for calling attention to this important subject. People who have never had occasion to analyse even qualitatively a mixture of three or four drugs (not necessarily official in the British Pharmacopœia) can have no idea of the immense amount of labour which the three pages of analyses of proprietary medicines given on pp. 36-39 must have entailed, and although Dr. Hutchison may have missed one or two unimportant ingredients, the results are ample to show how little justification manufacturers of these "quack" remedies have for their glowing advertisements. Many are palpable frauds, others are mixtures of drugs that are commonly prescribed, and some are ordinary household remedies hidden by colouring matters, &c. With characteristic generosity Dr. Hutchison admits that the makers sometimes recognise that drugs which have fallen into disuse among medical men are still very valuable, but these are the exceptions. Obesity preparations and drink cures are considered, as well as liver pills and cough mixtures, and some very sensible observations are made on the ethics of patent medicines, and finally Dr. Hutchison shows how quackery may be fought. He very justly remarks that the crusade against quackery ought to be undertaken by an official body, and not be left to the initiative of private individuals. We congratulate Dr. Hutchison on the able way in which he has striven to bring home to the medical profession the fact that they can all help in lessening the power of the patent medicine proprietor over the general public, and we hope that these papers will receive the moral and practical support of the profession.

(a) "Patent Foods and Patent Medicines." Two Lectures by Robert Hutchison, M.D. F.R.C.P. London: John Bale, Sons, and Danielsson, Ltd. 1904. Pp. 45. 1s. net.

## CLINICAL HANDBOOK OF URINE ANALYSIS. (a)

As the author remarks in his preface, this is an attempt "to place before the clinical student and medical practitioner the essentials of clinical urine analysis in a *brief, simple, and convenient form*."

"The methods described are, as a rule, those which have been most fully studied, and which are at present considered the most suitable for *clinical requirements*."

The opening chapter is entitled "Collection for Analysis," where valuable hints are given as to the best means and conditions of taking samples for the different examinations and the author gives the student the benefit of his experience in the preservation of urine during the time that elapses between micturition and analysis. Then follows a "Scheme of Urine Analysis," and the remainder of the book is divided into two parts: Qualitative Examination and Quantitative Methods. In the chapters on "Physical Examination," the author discusses the causes and significance of variations in quantity, colour, odour, reaction, specific gravity, transparency and the deposit in a most able and satisfactory manner. A consideration of the deposit occupies pp. 24-49, but we should have liked to see the use of such a stain as Jenner's blood stain recommended as being of considerable assistance to the beginner in facilitating the detection of leucocytes, epithelial cells, and other objects likely to be present in the organised deposit. Such a stain is, of course, superfluous after the operator has had much experience in the microscopical examination of the sediment.

Four pages are devoted to the detection of the gonococcus and the bacillus tuberculosis, but it would have been well to add that the gonococcus does not grow readily on gelatine, and for the information of the operator a list of the other organisms found in the urethra and vagina of healthy persons, which resemble the gonococcus, should be given to impress on the student the great care necessary before it is advisable to give an opinion regarding the presence of the gonococcus. Still, the author lays stress on the necessity of using Gram's method of staining, and the presence of the organism *within* the pus cells, and after a little practice it would be impossible for anyone to go wrong if he follows the instructions given. In the figure of gonococci (Fig. 2, Plate III.) the organisms are represented as if they were stained by Gram and the preparation counter-stained with eosin. Probably the figure is taken from a preparation stained with some blood stain, but in order to avoid possible errors due to the seeming contradiction of letterpress and figure, the colouring of this plate should be altered in the next edition. In the footnote on p. 35, the strength of solution of caustic potash used in the preparation of Löffler's alkaline methylene blue is given as 10 per cent. This is obviously a misprint for 0.01 per cent. Both in the case of the gonococcus and the tubercle bacillus, it is always advisable—indeed, most people consider it a necessity—to "fix" the film preparation by passing it three times through the flame. The "Qualitative Chemical Examination" is well written, and we heartily endorse Dr. Bedford's recommendation that in testing for albumin, the heat, nitric acid, and picric acid tests should all be employed. There can be no doubt that traces of albumin are frequently missed because of the slovenly way in which students and others test for it.

Part II deals with quantitative methods, and here the author has to describe volumetric methods in preference to gravimetric, owing to the latter requiring an accurate chemical balance. He, however, makes a very wise choice of the numerous volumetric methods that are in use, but we might point out that in the estimation of glucose by Pavy's method it is advisable to dilute the urine with dilute ammonia, as this greatly lessens the risk of the precipitation of cuprous oxide. Three pages are devoted to calculi, and there is a

chapter on "Cryoscopy" and "Drug Tests of Renal Excretory Power." The book closes with three Appendices and ten plates; the latter are unusually well produced, the exception being that of gonococci in pus cells, mentioned above, and the plate of tubercle bacillus, which would not be of much use to a practitioner who was unacquainted with the organism.

## MILK: ITS PRODUCTIONS AND USES. (a)

DR. WILLOUGHBY is well known in the scientific world and as the contributor of the article on milk for the "Encyclopædia Medica," and his experience is such as to commend the book now under consideration to the notice of all interested in milk. We consider that he is somewhat erring on the side of modesty in considering that his work will chiefly interest medical officers and "gentlemen in the country who engage in dairy work," for it contains matter which, though not strictly analytical, will be of value to analysts, and though not professing to be a farmer's manual, it will appeal to that class owing to the useful information that it contains on the breeds of cows and their relative values from a milk production point of view.

Finally, there is another class of men to whom this book will be exceedingly welcome—namely, sanitary inspectors. These men have not merely to assist in the carrying out of the Foods and Drugs Acts, by taking samples for analysis, but have to assist the medical officers in tracing the cause of outbreaks of disease communicated by milk, and in addition to see to the carrying out of the provisions of the Acts dealing with dairies, cow-sheds and milk-shops.

There has been up to the present no book of convenient size and reasonable price which contains so much information in a concise form. There are analytical treatises which go more fully into the matter of the composition and testing of milk in the laboratory, but these works do not contain the all-round information which is given here.

The book is divided into fifteen sections, beginning with the breeds of cattle, choice of cows, their housing, their food and diseases. After this the legal aspect of disease is dealt with, the Acts dealing with it, the elimination of tuberculosis, and the control of cow-sheds and dairies.

Next the composition of milk and milk products is considered, the relation of milk and disease; after which comes a section on the construction of the dairy, and the appliances used therein—refrigerators, separators, churns and the like.

Section thirteen deals with milk analysis, and in our opinion this might with advantage have been extended. The description of taking the specific gravity by means of a Sprengel tube is, however, a waste of space, as a float or a Westphal balance is always employed in practice.

Again, in estimating the total solids no one would operate on so small a quantity as a gramme, nor are methods depending on the use of asbestos employed in this country.

The methods for the estimation of fat in milk are well and accurately described.

On page 232 the author says, "Salt, cane-sugar, and dextrin are occasionally added to restore the specific gravity lowered by watering." Has the author ever personally come across such instances? The amount of salt required to restore the gravity lowered by watering would surely be so great as to be tasted.

The subject of preservatives, which is now one of extreme importance is dismissed in two and a half pages, and we find no mention whatever of the use of boro-fluorides. We are glad to find on page 243 the author frankly states that preservatives should not be permitted in milk intended for the use of infants, nor (by inference) should they be permitted in milk at all.

(a) "A Clinical Handbook of Urine Analysis." By Charles H. Bedford, D.Sc., M.D. Edin. With illustrations, 10 plates, and three Appendices. Second Edition. Pp. 172. Edinburgh: Bell and Bradburne. 1904.

(a) "Milk: its Productions and Uses. With Chapters on Dairy Farming, the Diseases of Cattle, and on the Hygiene and Control of Supplies." By Edward F. Willoughby, M.D. Lond., D.P.H. Lond. and Camb. Pp. 269, with 65 illustrations. Price, 6s. net. London: Charles Griffin and Co., Ltd.

The last section contains an account of the bacteriology of milk, together with the methods of staining the organisms most likely to be found.

We congratulate the author on the successful way in which he has completed his task of making a readable book, free from padding, but yet containing so much useful information that we predict that a second edition will speedily be required.

#### INTERNATIONAL CLINICS. (a)

The first two volumes of the Fourteenth Series of "International Clinics" are, as regards the subject-matter which they contain, somewhat disappointing. That this must necessarily be the case will be apparent when it is stated that almost every communication, especially in Volume I., appears to have been written, not because the author has something new and important to state, or because he is capable of setting forth the ordinary clinical facts of medicine in a specially attractive form, but because it is wanted as so much copy to help in the making of a book. It would be invidious to single out any individual communications for condemnation, and without doubt it must be at times difficult for the editor to make a selection that will please everybody, but there need be no hesitation in saying that the papers worth reading in the two volumes could easily be contained in one.

Among the best papers in Volume I. are "The Chloride Reduction Treatment of Parenchymatous Nephritis," by Messieurs Vidal and Gaval, and "The Practical Application of Cryoscopy to Medicine," by Dr. Cattell. The former of these is carefully and thoughtfully written, and will well repay perusal, while the latter is an admirable summary of the subject with which it deals. The review of the progress of medical science during 1903 contained in this volume is also excellent.

The first section in Volume II. deals with the diseases of warm climates, and most of the papers in it are fairly good, the best perhaps being those on Hæmoglobinuria and liver abscess. The remaining papers in this volume with the exception of that on Osteomalacia are sketchy and commonplace.

We would like to ask the author of the paper on the "Treatment of Ovarian Lesions," for his evidence of the statement (p. 156, Vol. I.) that "the normal mature Graafian follicle is from 0.5 c.m. to 2.0 c.m. in diameter, and there are in normal ovaries usually eighteen or twenty of these more or less fully developed follicles." Again, on page 62, Vol. II. we presume that it is 30 grains and not 30 grams (*sic*) of quinine Sulphate that are recommended to be taken within four hours.

In contrast to the text, the illustrations in both volumes are of great value, and are splendidly executed. They largely compensate for the other defects that have been noted. The books are nicely bound and printed, and are provided with a good index.

#### REPORT OF THE ARMY MEDICAL DEPARTMENT FOR THE YEAR 1902.

THIS Report possesses more than usual interest in being the first since the cessation of hostilities in South Africa. In view of the public attention which has been drawn to physical deterioration, those parts of the Report which deal with the recruiting of the Army are of special interest. We learn that 307.9 per 1,000 recruits were rejected on inspection, a figure which, compared with the previous year, shows an increase of 26.77. On looking into the causes for rejection, we find that the majority, namely, 4,969, were due to under chest measurement. Loss or decay of teeth follows next with 4,316, while defective vision is responsible for 3,437 rejections. All these numbers are from a total of 87,609 inspected.

We cannot help drawing attention to the Reports on

(a) "International Clinics: A Quarterly of Illustrated Clinical Lectures." Fourteenth Series. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, U.S.A. London: J. B. Lippincott Co. 1904.

surgical operations given in each of the commands, as the classification adopted might certainly be improved. On page 84, we find among the principal surgical operations "one for primary syphilis and one for gonorrhœa."—this leaves much to the imagination as to the exact operation which was performed.

On page 13 it is stated that there were 130 admissions for non-venereal ulcer (the cause of which is not stated) for the United Kingdom, and on page 233, 100 admissions for India, while throughout the Report several other cases are given. From this and from other parts of the Report one would think that non-venereal ulcer of the penis was a common lesion.

In the Report on South Africa we notice that a very frequent cause of invaliding was "caries of teeth," and that this disease alone provided 152 invalids, giving a ratio of 3.35 per 1,000. We are glad to know that steps have at last been taken to look after the teeth in the Army, and surely it would have been more economical to have had these men properly treated in South Africa.

With regard to the sanitary conditions in South Africa some very interesting extracts are given from a Report by Lieut.-Colonel Macpherson, C.M.G., R.A.M.C., on the sanitary conditions likely to affect the health of troops in cantonments and encampments in South Africa. This Report which, has been circulated as an official publication, very clearly brings to notice the backward state of civil sanitation and of sanitary administration in both large and small towns in South Africa, an unsatisfactory state of matters which is probably due, not so much to want of will on the part of the local authorities, as to want of money.

The Indian Report shows that there has been an increase in the number of cases of enteric fever in India, and this increase is attributed to the arrival of large drafts and reliefs from active service in South Africa. There seems to be a special predisposition on the part of the young soldier to acquire enteric during his first year in India, and the very considerable increase in the number of men of the most susceptible age will, to some extent, account for an increase in the actual number of admissions. There were two fatal cases of hydrophobia, and we are glad to learn that during the year the Pasteur Institute at Kasauli, under the charge of Major D. Semple, M.D., R.A.M.C. has continued its good work; 120 patients connected with the British troops in India were treated in the Institute; of these, sixty were bitten by animals proved to have had rabies; eighteen by animals certified by a veterinary surgeon to have had rabies; and forty-two by animals suspected of rabies; not a single one of these cases developed hydrophobia.

It is unfortunate that these valuable Reports should be practically out of date by the time that they are published, but we suppose that it is impossible to avoid their being so.

#### OPPENHEIM'S NERVOUS DISEASES. (a)

PROF. OPPENHEIM'S work is so well known and so highly valued by all neurologists, both on the Continent and at home in its original form, that we feel sure this second edition of the English translation will find many to welcome it. The new matter added to the third German edition has been translated and inserted into this, and the editor has also added the results of research and investigation in the field of neurology since the revision of the German original. Though described on the title-page as a text-book for students and practitioners the work before us differs considerably from what we expect to find in the ordinary text-book, and in these differences lie no inconsiderable part of its charm. The individuality of the author is stamped

(a) "Diseases of the Nervous System: A Text-book for Students and Practitioners of Medicine." By H. Oppenheim, M.D., Professor at the University of Berlin. Translated and edited by Edward E. Mayer, A.M., M.D. Second American edition, revised and enlarged. With 848 illustrations. London: J. B. Lippincott Co. 1904. Price 21s. net.

on every page, and one can well believe his remark that all he has written "is corroborated by personal observation and knowledge."

Our author divides his work into two parts—a general and a special. In the first he treats of the methods of examination, general symptomatology and objective examination; while in the second he treats of the diseases of the cord, the peripheral nerves, the brain, the neuroses, the sympathetic nervous system, and toxic conditions. In dealing with the general examination, Professor Oppenheim mentions only such methods as are likely to be of use clinically. Instruments like aesthesiometers and algesimeters and the "exact measures" used by physiologists are impracticable at the bedside. The electrical examination is very well and fully described, and Erb's figures illustrating the motor points are given, but the use of such figures is greatly lessened by the absence of all anatomical description of their position.

A most interesting feature of the work is the anatomical and physiological description of the nervous system which is prefixed to the sections dealing with the diseases of the spinal cord, peripheral nerves, and the brain. The most recent anatomical investigations of these structures are described and discussed with such clearness and fulness that these sections might be used almost as a text-book on the physiological anatomy of the nervous system. This wealth of anatomical and physiological detail is perhaps the cause of, as it certainly brings more into prominence, the absence of information on the psychological aspect of the nervous system. Professor Oppenheim does deal shortly with hypnotism, and admits it as a valuable therapeutic agent in certain cases; but we miss any suggestion as to the *rationale* of its action or even any criticism of the explanations that have been given of it by others. Surely, however, it is now impossible adequately to discuss the nature of the neuroses or their pathology in the absence of psychological investigation. The study of psychology has, however, been so long neglected by the ordinary medical man that its absence from the work before us will, we believe, be looked upon as an advantage rather than an omission by the majority of its readers. That these readers will be numerous we are fully convinced, and we look forward to seeing the book become one of the standard text-books on neurology among students.

#### HOLT'S CARE AND FEEDING OF CHILDREN. (a)

This is the third edition of a catechism of infant management originally published in America. It is now presented to us in a somewhat enlarged and improved form, with the addition of an introduction from the pen of Dr. Eric Pritchard. The book is intended for the use of mothers and nurses, but in our opinion it is better suited for students of infantile disease and for general practitioners. We have scarcely advanced so far in this country as to entrust the care of infants to nursery maids or even to parents entirely. It is a good thing for medical practitioners that the public are not too skilled in such matters, otherwise some of us might have little enough to do. We fear that a book such as this, if put into the hands of the laity, would to a large extent supplant the family physician. As we have said already, it is more suitable for students and practitioners. The best part of the book is undoubtedly that dealing with the feeding of infants and young children. There is, perhaps, no subject so little understood by the general practitioner as that of infant feeding. Too often artificial foods are ordered regardless of the fact that their usual effect is to produce rickets. Holt has little or nothing to say regarding such foods. In fact, he practically condemns their use when he says (p. 46) that they are "attended with great risk."

(a) "The Care and Feeding of Children." By L. Emmett Holt, M.D., LL.D., Professor of Diseases of Children in the College of Physicians and Surgeons (Columbia University), &c. With an introduction by Eric Pritchard, M.A., M.D., Oxon., M.R.C.P., Lond. Third Edition, revised and enlarged. pp. 149. Price 2s. net. London: Sidney Appleton. 1904.

We understand that this book has met with great success in America, and we have no doubt that physicians in this country will appreciate it quite as much. It gives a very clear outline of the subject with which it deals, and the form of question and answer serves to impress the various facts upon the mind of the reader. In another edition an index might with advantage be added.

#### HAAB'S ATLAS OF EXTERNAL DISEASES OF THE EYE. (a)

This number of the Medical Hand-Atlas Series is a worthy companion to Professor Haab's "Atlas and Epitome of Ophthalmoscopy and Ophthalmoscopic Diagnosis." The fact that it has reached already a second edition proves that it is widely accepted amongst students and general practitioners.

Starting with an excellent chapter on the "Examination of the Eye in Disease" (including a subdivision on the "Detection of Malingerers") the reader is presented with pictures, in print and colours, of the most important external diseases of the eye, beginning with lachrymal diseases and ending with those affecting the orbit. The forty-eight chromo-lithographic plates serve admirably to place before the reader the actual appearance of the various diseases. Each illustration represents a case, the history of which is given in small type on the top of the opposite preceding page—a method worthy of commendation, as it enables one to read the description of the case most readily, while occasionally referring to the illustration for elucidation of the text.

Professor Haab's teaching is broad-minded, and is what one would expect from a man of so great clinical experience, while his editor, Dr. de Schweinitz, does not hesitate to add comments which in several instances present views at variance with those of Dr. Haab.

This form of ophthalmic text-book has much to recommend it from a student's point of view, if the illustrations be well done, as they are in Dr. Haab's books. For it is often a matter of great difficulty to explain to a student by black and white illustrations many of the diseases of the eye, while these difficulties are easily removed by a well-executed coloured illustration.

We can cordially recommend this book to students and general practitioners.

#### THE CASE AGAINST ANTI-VIVISECTION. (b)

In the short and incisive preface prefixed to this little volume, the author tells us that, "The writer of this pamphlet hopes against hope that it will not give grave offence where no offence is intended. Unhappily for him, it is bound to be aggressive. But there is one thing to be said for it, that it keeps close to its subject, which is the methods, literature and arguments of the anti-vivisection societies. It is concerned with them and with nothing else; it puts the case against these societies, and there stops." In discharging the reviewer's task, it is, of course, to us a very patent fact, as well as to every one of our readers, that an elaborate attempt to analyse the garbled statements and limping logic of the anti-vivisectionists can be nothing but a pure waste of time and space. Every medical man, who is in touch with the progress and present status of professional knowledge, knows the principal results obtained by the Vivisectionists; he also knows the principal statements and arguments

(a) "Atlas of the External Diseases of the Eye, including a Brief Treatise on the Pathology and Treatment." By Prof. Dr. O. Haab, of Zurich. Authorised Translation from the German. Second edition, revised. Edited by G. R. de Schweinitz, A.M., M.D., Professor of Ophthalmology in the University of Pennsylvania, &c. 98 coloured lithographic illustrations in 48 plates. pp. 252. Philadelphia, New York, London: W. B. Saunders and Co. 1903. Price 1s. net.

(b) "The Case Against Anti-Vivisection." By Stephen Paget. 8vo, pp. 104. Price, limp cloth, 1s. 6d. net. London: The Scientific Press, Ltd. 1904.

put forward by the Anti-Vivisectionists. Accordingly had it not been for the continuous endeavour of the latter section of the public to influence our legislators, and prejudice the general public against the most important methods for the advancement of physiological and pathological science, there would be hardly any object in our noticing Mr. Paget's excellent pamphlet. The contents of this are divided into four chapters: I., Anti-Vivisection Societies; II., Literature; III., Arguments; IV., "Our Cause in Parliament." The two latter are, of course, specially deserving of attention at present. The reader who wants to reason his wavering friends out of the fallacies and mis-statements of the Anti-Vivisectionists, should fill his quiver with the weapons provided in the chapter of "Arguments"; and he who is anxious to diminish their future power of legislative mischief should make himself thoroughly acquainted with the last chapter. We cordially congratulate Mr. Paget on the brilliant contribution to the "advancement of science," which we have just read.

#### VENTRE. (a)

THIS volume is so beautifully printed and illustrated that it must secure a certain proportion of attention by these features alone. But it has many other claims. The writer is evidently an enthusiast in the speciality, and has thought it out in all its departments with laborious care and thoroughness. The work of such an author is always deserving of careful scrutiny; it can never fail to illustrate its subject by some new light, even if that light be, in some instances, merely the reflection of the beam, which led the author himself astray. Dr. Bourcart claims for the present work that it is destined to place before the reader, in a scientific point of view, a really new method of treatment "cavertant que procédé exclusif et se suffisant à lui-même, le massage localisé à l'abdomen est de date récente." The author is, very evidently, a past master of his subject, and is prepared to defend his positions with skill and vigour. Nevertheless, it is well to point out that such exclusive statements are peculiarly open to critical aspersion. When the late Sir Henry M. Stanley crossed the "Dark Continent" for the purpose of inflicting "relief" upon Emin Pasha, he was accompanied by a troop of Zanzibaris, mostly as primitive members of the human family as could be found anywhere. We have the testimony of the brave and chivalrous Irish surgeon, Thomas Heath Parke, who was the medical officer of that expedition, to the fact that when one of those dark-complexioned natives became afflicted with abdominal twinges, his favourite procedure was—when collateral circumstances proved non-conflicting—to place himself on the ground, in the supine posture and horizontal plane, and there and then have his abdomen "walked on" by one of his (barefooted) compatriots. And very effective was this pre-scientific mode of applying localised abdominal massage reported to be! And we may be pretty sure that directly after the eviction of our common ancestor from the Garden of Eden and the beginning of his liability to the ills of the flesh, he practised massage when his great toe abruptly collided with an unexpected fragment of rock, or his shin with a fallen tree. And when the abdominal surface received the impact of a foreign body with a very unusual amount of *vis viva*, we feel pretty certain that the good offices of Eve were requisitioned for the purpose of diminishing by pressure and friction the personal inconveniences to which her curiosity and disobedience had rendered her fallen spouse liable. That massage is the most primitive weapon in the surgical armamentarium we have no doubt whatever. But it is only of recent years that its application has been reduced to approximate scientific order. Our author tells us in his preface that, "C'est par le développement scientifique du massage gynécologique que le

*massage scientifique du ventre s'est créé*," and he promptly adds that "c'est par les travaux des premiers pionniers de langue française qui se sont rendus à Stockholm (Jentzer et moi d'abord; puis Stapfer et d'autres encore) que l'élan a été donné." The sketch of the surface anatomy of the abdomen is a good one, and copiously illustrated—after the Paris "Salon" style; the account of the internal anatomy is also good, and very clearly put—as French word painting usually is. The directions for renal massage are excellent, and the accompanying illustrations are worthy of all praise.

#### THE NATURE OF MAN. (a)

DR. MITCHELL, in presenting this work to English readers claims that Metchnikoff "has gained the right to a hearing by forty years of patient devotion and brilliant research. In the volume now given to the public he has addressed himself to the gravest and most serious problems of humanity, to life and sex and death and the fear of death." And the somewhat startling statement is made that "now for the first time in the history of thought, the exact methods of science have been brought to the statement of these problems."

The work is certainly a remarkable one, and not without danger in its fascination, but nevertheless rich in suggestiveness and stimulating to serious thought. Metchnikoff has well won a high reputation as a biologist, but pathologists know that he has also some of the elements which go to make a great romancer. The contents of the present volume are perhaps best considered as the products of the recreative hours of an ageing naturalist desirous of contributing something to the conceptions of human existence before the curtain is rung down on the individual observing life.

The author has turned aside from the day's pursuit to wander into regions which the lamp of science will probably never enlighten. He attempts to dabble in the deep waters of faith and tries to sound the depths of religious belief with the short line plummet allowed by science. The result is oftentimes disappointing, and Metchnikoff in these pages has done himself grave injustice by departing from the position of a reverent agnostic and assuming a dogmatism which is lacking in scientific spirit and indecorous to certain of the dearest beliefs and desires of the keenest thinkers.

We fear the enigmas of life and death are not to be revealed by such brilliant but misleading presentations as are contained in these pages.

The volume is divided into three sections, and deals respectively with the disharmonies in the nature of man; attempts to diminish the ills arising from the disharmonies of the human constitution (religious and philosophical systems); and what science is able to do to alleviate these disharmonies.

We cannot attempt to survey the many features of this striking work, for every chapter affords material for careful consideration, and is capable of initiating endless discussion. The many references will prove invaluable to students and no one can read these pages without being impressed by the importance of the subjects raised. It is, however, a work which needs to be read with wise discernment, and is hardly a volume to be placed thoughtlessly in the hands of untrained laymen. The insistence on the view that disharmonies in the human constitution are the chief sources of our sorrows may serve to solve some of the problems of human existence, but we fear the doctrines set forth in this book, ingenious and peculiarly fascinating as many of them are, will hardly lighten the burden which many have to carry, or serve as directing light along life's dark pathway.

(a) "Le Ventre: Etude Anatomique et Clinique de la Cavité Abdominale au point de vue du Massage. I. Le Rein." Par Dr. M. Bourcart. Ouvrage illustré de 184 figures. Genève: H. Kundig, Editeur. Paris: F. Alcan, Editeur. 1904.

(a) "The Nature of Man: Studies in Optimistic Philosophy." By Elite Metchnikoff, Professor at the Pasteur Institute. The English translation edited by P. Chalmers Mitchell, M.A., D.Sc. (Oxon.), Secretary of the Zoological Society of London. Pp. 288. 20 Figs. London: William Heinemann, 1903. Price 12s. 6d.



## Literary Notes and Gossip.

"LEMCO Dishes for all Seasons," issued by the Leibig's Extract of Meat Co., is not only a useful and artistic advertisement of the manifold advantages of the preparation they are pleased to call by the fanciful and euphonious name of "Lemco," but is an ingeniously arranged and thoroughly serviceable cookery book which we commend to the consideration of nurses and those who may be called upon to prepare appetising dishes for the sick and delicate.

THE forthcoming number of the *British Journal of Inebriety*, the official publication of the Society for the Study of Inebriety, will contain an important article on "The Criminal Responsibility of the Alcoholic," by Dr. W. C. Sullivan, and also a criticism by Dr. Harry Campbell on certain recently promulgated views on the pathology of chronic alcoholism.

THE August number of the *Journal of the American Medical Association* contains a special article on the History of the United States Public Health and Marine Hospital Service. A well-merited tribute of praise is given to Surgeon-General Wyman, who by his admirable foresight and diplomacy saved the country in 1892 from the threatened cholera invasion. The same officer has been mainly responsible for the expansion and centralisation of public health work in America, and was also one of the first to suggest a plan for international sanitation of sea-ports. Among the "original articles" is one on "Static Foot Error," by W. P. Blodgett, M.D. The incidence of these troubles is tabulated according to sex, age, time of year, occupation and etiology. Pain in the ankle region is said to be the most common symptom, and it is pointed out that while relief is usually obtained by the use of suitable spring supports, it is only in very few cases that such supports can ever afterwards be dispensed with. In a paper entitled "Practical Notes on Ointments: their Use and Abuse," Dr. Duncan Bulkley points out the principal indications for the use of ointments, and also gives some practical hints on the way to compound them. Dr. V. A. Latham reports on a case of "Neoplasm of the Pulp," which he regards as a carcinoma. He considers his case important with reference to the site of origin of tongue and gum cancers.

THE July "Bulletin" of the Johns Hopkins Hospital, Baltimore, contains (1) "The Sensory Distribution of the Fifth Cranial Nerve," by Harvey Cushing, M.D. In this most valuable article Dr. Cushing gives us the results which he has obtained by a careful examination of the area of anaesthesia left in patients by destruction or avulsion of the sensory root of the fifth nerve. In all twenty-six cases were examined, and the examination was made in most of them shortly after the operation. The area of anaesthesia mapped out corresponds closely with that figured by Frohse, as the results of his anatomical studies. Posteriorly it includes a portion of the helix of the auricle, and also the anterior wall of the external auditory meatus. This is what would be expected from a study of the development of these parts, inasmuch as these portions of the ear are developed from the mandibular arch. Cushing also points out the important fact that the skin areas supplied by the different branches of the fifth nerve do not overlap. (2) "Stephen Hales, the Physiologist," by Percy M. Dawson, M.D. This is an interesting historical sketch dealing chiefly with the physiological experiments of Hales. (3) "The Chemical Origin of Leucocytes," by E. Schnoll, M.D. The object of this elaborate research was to answer the question "Is the adult human body capable of synthesising nucleins from nuclein free food, or is it dependent for its nucleins upon those ingested in the food?" To answer this Schnoll investigated the blood in leukaemic cases. While feeding these cases on (a) ordinary diet, (b) purin-free, albumin rich diet (c) mixed purin-albumin rich diet, (d) purin rich and

albumin rich diet, he found that the number of leucocytes increased in the blood with increase of albuminous diet, irrespective, apparently, of the nuclein contents. His observations are too few, as yet, for a definite conclusion, but so far he is led to believe that nucleins can be manufactured in the adult body. (4) "Mental Phenomena and Visceral Disease," by Carey B. Gamble, jun., M.D. In the proceedings of the Hospital Medical Society Dr. Painter read an interesting communication on the "Pathology of Rheumatoid Diseases," and a case of tuberculosis of the parotid gland was exhibited by Professor Osler.

OUR youthful contemporary, the *South African Medical Record*, a monthly journal devoted to the interests of the medical profession in South Africa, has for the most interesting paper in the August number one by Dr. P. D. Strachan, entitled "The Question of the Presence in South Africa of Undulant or Malta Fever." In it he points out that a number of cases of fever are met with in South Africa which, although usually called typhoid fever, bear a most close resemblance clinically to Malta fever. That they are not malarial in origin is proved by the examination of the blood, and by the inefficiency of quinine in treatment. Up to this Dr. Strachan has been unable to make use of bacteriological methods of diagnosis, but he hopes to do so shortly, and will make known his results. The question of medical advertising is dealt with in a strongly worded editorial. Advertisements of medical men, both direct and indirect, had become so common that recently the Cape Medical Council was compelled to endeavour to put a check to it by dealing severely with all cases that came under its notice. This has led in some cases to hardship, and, in consequence, there has been some outcry against its decrees. We are glad, however, to see that the Council is determined to uphold the position that it has taken up, and will in future enforce fully its decrees. As an example of a common (indirect?) method of advertisement, and one of a peculiarly objectionable type, we may quote the following, which appeared in the *Cape Times* of April 19th: "I hereby tender my sincere thanks to Dr. Wood, Dr. Pringle, and Dr. Drew, also to the Sister of the Brickersteth Ward, New Somerset Hospital, for the kindness and attendance to me during my stay at the hospital."

THE 60th Annual Report of the British Medical Benevolent Fund, for the year 1903 has just been issued and should be studied by all who are in any way able, either by sympathy or financial support, to assist in the relief of distressed qualified members of the profession, their widows and orphans. This excellent work deserves the highest praise and most unqualified approval and practical encouragement.

### NEW BOOKS AND NEW EDITIONS.

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

- ADLARD AND SONS (London).  
Asthma in Relation to the Nose. By Alexander Francis, M.B., B.C. Cantab. Pp. 136. Price 3s. net.
- BAILLIERE, TINDALL AND COX (London).  
Adenoids. By Wyatt Wingrave, M.D. (Medical Monograph Series, No. 9.) Illustrated. Pp. 128. Price 2s. 6d. net.
- A Manual of Practical Medical Electricity. By Dawson Turner, B.A., M.D., &c. Fourth Edition, revised and enlarged. Illustrated. Pp. 433. Price 10s. 6d. net.
- Diseases of the Stomach and their Surgical Treatment. By A. W. Mayo Robson, F.R.C.S., and B. C. A. Moynihan, M.S. Lond., F.R.C.S. Second Edition. Illustrated. Pp. 508. Price 15s. net.
- Railway and Other Accidents with Relation to Injury and Diseases of the Nervous System. A Book for Court Use. By Allan W. Lane Hamilton, M.D., F.R.S.E. Illustrated. Pp. 351. Price 15s. net.
- The Cancer Problem in a Nutshell. By Robert Bell, M.D., F.F.P.S., &c. Pp. 39. Price 1s. net.
- Practical Chemistry, including Simple Volumetric Analysis and Toxicology. By P. A. Ellis Richards, F.I.C. Pp. 136. Price 3s. net.
- JOHN BALE, SONS AND DANIELSSON (London).  
Adenoid Growths of the Naso-Pharynx. Diagnosis, Symptoms, and Treatment. By G. A. Garry Simpson, M.R.C.S. Eng. Illustrated. Pp. 43. Price 3s. 6d.
- CASSELL AND CO., LTD. (London).  
Serums, Vaccines, and Toxins in Treatment and Diagnosis. By Wm. Cecil Bosanquet, M.A., M.D. Pp. 344. Price 7s. 6d.

- The Student's Handbook of Surgical Operations. By Sir Frederick Treves, Bart., K.C.V.O., C.B., LL.D., F.R.C.S. New Edition, revised by the Author and Jonathan Hutchinson, [jun.], F.R.C.S. Illustrated. Pp. 486. Price 7s. 6d.
- J. & A. CHURCHILL (London).
- Beri-Beri: its Symptoms and Symptomatic Treatment. An Essay by Percy Netterville Gerrard, B.A., M.D., &c., &c. Pp. 95. Price 2s. 6d. net.
- Clinical Diagnostic Bacteriology. By Alfred C. Coles, M.D., D.Sc., F.R.S. Edin., with coloured plates. Pp. 237. Price 8s. net.
- The Development and Anatomy of the Prostate Gland. By W. G. Richardson, M.B., B.S., &c. Pp. 121. Price 10s. 6d. net.
- The Examination of Waters and Water Supplies. By John C. Thresh, D.Sc., M.D., D.P.H. Pp. 460. Price 14s. net.
- ARTHUR C. FIFIELD (London).
- The Ballad of Judas Iscariot. By Robert Buchanan. Pp. 21. Price 3d.
- Selections from Tennyson's "In Memoriam." Pp. 39. Price 3d.
- Culture. By Ralph Waldo Emerson. Pp. 38. Price 3d.
- Walkden; My Life in the Woods. By H. D. Thoreau. Pp. 158. Price 6d. net.
- Master and Man. By Leo Tolstoy. Pp. 96. Price 6d. net.
- Tolstoy as a Schoolmaster. By Ernest Crosby. Pp. 94. Price 6d. net.
- H. K. LEWIS (London).
- Enlargement of the Prostate. its Treatment and Radical Cure. By C. Mansell Moullin, M.D. Oxon., F.R.C.S. Third Edition. Pp. 204. Price 6s.
- J. B. LIPPINCOTT Co. (London).
- International Clinics. Vol. II. Fourteenth Series, 1904. Edited by A. O. J. Kelly, A.M., M.D. Philadelphia, U.S.A. Pp. 314.
- LONGMANS, GREEN AND Co (London).
- Elementary Practical Physiology. By John Thornton, M.A. Illustrated. Pp. 324. Price 3s. 6d.
- MACMILLAN AND Co., LTD. (London).
- The Story of an East London Hospital. Pp. 92. Price 2s. 6d. net.
- JOHN MURRAY (London).
- Handbook of Physiology. By W. D. Halliburton, M.D., F.R.S. Sixth Edition. Illustrated. Pp. 902. Price 13s. net.
- REEMAN, LIMITED (London).
- An Atlas of Human Anatomy. By Carl Toldt, M.D., assisted by Prof. A. D. Rosa, M.D. Translated by M. Eden Paul, M.D. Brux. Fifth Section, F. Angiology. Pp. 742. Price 13s. 6d. net.
- THE SCIENTIFIC PRESS, LTD. (London).
- The Pocket-Book of Temperature Charts. Price 6d. net.
- SMITH, ELDER AND Co. (London).
- An Index of Symptoms as a Clue to Diagnosis. By Ralph Winnington Lettwich, M.D. Third Edition. Pp. 399. Price 6s. net.
- YOUNG J. PENTLAND (Edinburgh).
- The Nervous Affections of the Heart. By George Alexander Gibson, M.D., D.Sc., &c. Illustrated. Pp. 99.

## Obituary.

### PROFESSOR NIELS FINSEN, OF COPENHAGEN.

THE death of Professor Finsen, at Copenhagen, on the 24th instant, has excited world-wide regret. Although he had attained the age of 43 only, his name had nevertheless become familiar in all civilised countries by reason of his famous discovery of the "light cure" for lupus. For years past his health had been precarious, so much so, indeed, that he had been unable to take an active part in the development of his original discovery. The great merit of his work was that which must always remain attached to the man who takes the first step on a new pathway of human knowledge and achievement. Finsen's name will be ever associated with the ultra-violet treatment of lupus and of other skin diseases. The ultra-violet rays occur naturally in sunlight, and may be obtained artificially by an electric arc light. Both methods were used by Finsen in his apparatus, and were shown by him to have a special action on the skin of man as well as a bactericidal effect on micro-organisms. In applying these rays he showed that they possess far greater power of penetration in bloodless tissues than in those filled with blood. In the original apparatus the light from a powerful arc lamp was led through a tube so arranged as to concentrate the violet and ultra-violet rays and to remove the heat rays. To effect this, water was kept running between quartz lenses. One of the latter pressed on a lupus for an hour or more daily for many months was found to cure the disease in almost all cases. The apparatus was costly and the course tedious, and Finsen's method has undergone numerous modifications in the direction of quickness, cheapness, and ease and convenience of application. It may be questioned whether, on the whole, ordinary surgical measures are not preferable in the treatment of lupus. Finsen, however, opened up to the medical world a fresh field of therapeutics, whose fruits may be some day both multitudinous and fair. In our own country the

Finsen light cure of lupus has been known chiefly in connection with the London Hospital. It was introduced there by Queen Alexandra, who furnished the necessary installation entirely at her own expense. Her Majesty, accompanied by her sister, the Dowager Empress of Russia, had become acquainted with the wonders of the new treatment at a visit to Professor Finsen's Medicinske Lysinstitut in Copenhagen, in April, 1899. Immediately on her return home Queen Alexandra communicated with the London Hospital. Shortly afterwards Dr.—now Sir—Stephen Mackenzie visited Copenhagen to study Finsen's methods, and later a matron and a nurse from the London Hospital followed for the same purpose. Not content with providing the means alone, we understand that Her Majesty sent the first patient in the person of a poor girl from Great Footers, near Egham. The Queen has followed the subsequent progress of the Finsen treatment at the London Hospital with the greatest interest and has paid frequent visits of inspection to that institution. The example of Dr. Finsen, who constituted to compass so much good work in a life so frail and brief, may well be held up as a pattern to all members of his humane and self-sacrificing profession.

### DR. CROKER, BELFAST.

THE death occurred last week, on the 22nd inst. of Dr. George Croker, one of the oldest practitioners in Belfast. If he had lived six weeks longer, he would have entered on his 90th year, having been born on October 31st, 1815, in Beaufield House, Co. Wicklow. He was for some years family physician to the Marquis of Downshire, and then surgeon to the Royal South Down Rifles at Hillsbro'. When the headquarters of the regiment was removed to Downpatrick, he retired from that post, and was appointed to a dispensary on the east side of Belfast, where he continued to practise till failing health obliged him to resign six years ago. To the present generation of medical men in Belfast, Dr. Croker was known as a most genial and kindly old gentleman, of the highest principles and old-world courtesy. His ruling passion was a love for animals of all sorts.

### DONALD FLUDYER BOULTON, M.R.C.S. ENG. L.S.A.

It is with regret that we have to record the death of Dr. Donald Fludyer Boulton, at his residence Newmarket Street, Usk, on the 11th instant. The deceased gentleman, who was 62 years of age, had a paralytic stroke three weeks ago. Dr. Boulton succeeded his father as surgeon at H.M. Prison, Usk about thirty years ago, was club doctor to two or three Friendly Societies in the town, and had an extensive practice. Dr. Boulton was a most enthusiastic sportsman, and was a keen follower of the Llangibby Hounds, and was often with the otter hounds. In his younger days he was a gentleman jockey, and rode winners at the local races. He was very popular and highly respected in the district generally. He was educated at St. Bartholomew's, and took the qualifications of membership of the R.C.S. and the L.S.A.

### THOMAS CHAPLIN, M.D. ST. AND., &c.

DR. THOMAS CHAPLIN, formerly of Jerusalem and afterwards of St. Leonards, died last week at his residence, St. Leonards, in his seventy-fourth year. Professionally educated at Guy's Hospital, he was admitted a member of the Royal College of Surgeons, England, and a licentiate of the Society of Apothecaries in 1853, and took the M.D. Degree at St. Andrews in 1858. He was formerly resident in Jerusalem where he was physician to the English Mission Hospital for Jews, honorary physician to the German Hospital and Leper Asylum, and President of the Jerusalem Medical Society. Dr. Chaplin, who was a honorary Associate of the Order of St. John of Jerusalem, was a member of the Council of the Victoria Institute and of the Executive Committee of the Palestine Exploration Fund. He had written, amongst other subjects,

on the "Fevers of Jerusalem," and for the Victoria Institute on "Some Diseases Mentioned in the Bible."

## Medical News.

### The Midwives Act.

WE are requested to publish the following resolution adopted by the Council of the Incorporated Medical Practitioners' Association:—"That we, the Council of the Incorporated Medical Practitioners' Association, at this our first meeting since the vacation, desire to place on record our protest against the action of the Central Midwives Board in deciding to appoint as examiners for the certificate of the Board non-medical women, thereby raising, to the level of the duly registered medical practitioner who has undergone an expensive course of study and a searching examination, women who are not required to show proof that they possess any knowledge of the different subjects which a medical practitioner has to study in order to obtain a diploma."

### Ankylostomiasis.

A COMMITTEE representing the South and West Yorkshire coalowners and the Yorkshire Miners' Association is engaged in devising measures to prevent the introduction of ankylostomiasis into the pits in Yorkshire. Among other steps it is intended to give lantern-illustrated lectures at the various mining centres, in order to secure the intelligent co-operation of the men. The two lecturers appointed are Dr. Porter of Sheffield and Dr. Vaughan Bateson of Bradford, the task of illustration being entrusted to Mr. Scott, the Secretary of the Committee.

### Carbolic Acid Poisoning.

MR. WALTER SCHROEDER, Deputy-Coroner for the Central District of London, stated, at an inquest at Hampstead recently, that since the Order in Council declaring that liquid preparations of carbolic acid and its homologues, containing more than 3 per cent. of those substances, are to be deemed poisons, the number of deaths, accidental or suicidal, from this cause has very greatly decreased. It will be remembered that it was largely owing to the exertions of the British Medical Association that the Order in Council was issued.

### Sir William MacGregor.

A DINNER was given on September 16th by Sir Alfred Jones, President of the Liverpool Chamber of Commerce, in honour of Sir William MacGregor, K.C.M.G., C.B., late Governor of Lagos, who has been appointed to the Governorship of Newfoundland. A sum of nearly £1,000 was subscribed by those present to be handed over to the Liverpool School of Medicine in the name of Sir William MacGregor in recognition of his services to sanitation in West Africa. Sir William MacGregor is a Doctor of Medicine of the University of Aberdeen.

### A Chemical and Pharmaceutical Congress.

A CONGRESS of Chemistry and Pharmacy organised under the auspices of the Pharmaceutical Association of Liège and the Chemical Society of Belgium, will be held in connection with the International Exposition to be held at Liège in July, 1905. In addition to technical matters, questions relating to legislation and professional ethics will be discussed. Communications should be addressed to one of the Secretaries, M. J. Raymond, 16, Place des Carmes, Liège, or M. J. Wauters, 83, Rue Souveraine, Brussels.

### West London Medico-Chirurgical Society.

THE following are the officers and members of Council for 1904-5:—President: Mr. C. M. Tuke.\* Vice-Presidents: Mr. C. B. Keetley, Mr. W. P. Barrett, Dr. G. H. D. Robinson, Mr. J. R. Lunn, Dr. E. Furniss Potter, Dr. E. Bromet,\* Dr. G. P. Shuter,\* Mr. H. Webb.\* Council: Mr. R. Pollock, Dr. A. M. Ross Sinclair, Mr. G. A. Garry Simpson, Dr. Percy Dunn, Mr. McAdam Eccles, Mr. E. P. Paton, Dr. A. Saunders, Dr. A. J. Rice Oxley, Dr. J. A. Mansell Moullin,\* D.

A. Morison,\* Dr. A. E. Russell,\* Dr. C. Buttar,\* Treasurer: Mr. T. Gunton Alderton. Secretaries: Dr. Andrew Elliot, Dr. W. H. Walter.\* Librarian: Mr. H. W. Chambers. Editor of Journal: Dr. Leonard Dobson. Editorial Secretary: Mr. J. G. Pardoe. (Those marked with an asterisk did not hold similar office last year.)

The evening meeting will be held at the West London Hospital on Friday, October 7th, at 8.30 p.m. The President, Mr. C. M. Tuke, will deliver an address on "Progress in Psychology."

### Requests to Medical Charities.

By the will of Mr. Thomas Whiffin, of Putney, who died on March 27th, the following bequests are directed to be paid, free of legacy duty:—£500 each to St. George's Hospital, St. Thomas's Hospital, Guy's Hospital, Charing Cross Hospital, the Metropolitan Free Hospital, Kingsland Road, King's College Hospital, the Middlesex Hospital, and the Victoria Hospital for Children, Queen's Road, Chelsea; £250 each to the Brompton Hospital for Consumption, the National Hospital for Paralysis and Epilepsy, Queen's Square, Bloomsbury, the Hospital for Women, Soho Square, the Samaritan Free Hospital, Marylebone Road, the City Orthopaedic Hospital, Hatton Garden, the Central London Ophthalmic Hospital, the Royal Hospital for Incurables, Putney, the Asylum for Idiots, Earlswood; the Royal Blind Pension Society, and the Royal Association in Aid of the Deaf and Dumb, Oxford Street.

### The British Gynaecological Society.

THE annual dinner of this Society will be held on Thursday, November 24th, at the Monico, Piccadilly Circus, at 7.30 p.m.

### The Royal Academy of Medicine in Ireland.

THE annual general meeting of the Royal Academy of Medicine in Ireland will be held on Friday, October 14th, at 4.30 p.m., at the Royal College of Physicians, Kildare Street, when the report will be submitted and the election of officers will take place.

## OPERATIONS.—METROPOLITAN HOSPITALS.

WEDNESDAY.—St. Bartholomew's (1.30 p.m.), University College (2 p.m.), Royal Free (2 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. Thomas's (2 p.m.), London (2 p.m.), King's College (2 p.m.), St. George's (Ophthalmic, 1 p.m.), St. Mary's (2 p.m.), National Orthopaedic (10 a.m.), St. Peter's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), St. Ormond Street (9.30 a.m.), St. Northern Central (2.30 p.m.), Westminster (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Cancer (2 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

THURSDAY.—St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), University College (2 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), London (2 p.m.), King's College (2 p.m.), Middlesex (1.30 p.m.), St. Mary's (2.30 p.m.), Soho Square (2 p.m.), North-West London (2 p.m.), Chelsea (2 p.m.), Great Northern Central (Gynaecological, 2.30 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), St. Mark's (2 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

FRIDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Charing Cross (3 p.m.), St. George's (1 p.m.), King's College (2 p.m.), St. Mary's (2 p.m.), Ophthalmic (10 a.m.), Cancer (2 p.m.), Chelsea (2 p.m.), Great Northern Central (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), City Orthopaedic (2.30 p.m.), Soho Square (2 p.m.).

SATURDAY.—Royal Free (9 a.m.), London (2 p.m.), Middlesex (1.30 p.m.), St. Thomas's (2 p.m.), University College (9.15 a.m.), Charing Cross (2 p.m.), St. George's (1 p.m.), St. Mary's (10 p.m.), Throat, Golden Square (9.30 a.m.), Guy's (1.30 p.m.).

MONDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (2.30 p.m.), St. George's (2 p.m.), St. Mary's (2.35 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), Chelsea (2 p.m.), Samaritan (Gynaecological, by Physicians, 2 p.m.), Soho Square (2 p.m.), Royal Orthopaedic (2 p.m.), City Orthopaedic (4 p.m.), Great Northern Centre (2.30 p.m.), West London (2.30 p.m.), London Throat (9.30 a.m.), Royal Free (2 p.m.), Guy's (1.30 p.m.).

TUESDAY.—London (2 p.m.), St. Bartholomew's (1.30 p.m.), St. Thomas's (3.30 p.m.), Guy's (1.30 p.m.), Middlesex (1.30 p.m.), Westminster (2 p.m.), West London (2.30 p.m.), University College (2 p.m.), St. George's (1 p.m.), St. Mary's (1 p.m.), St. Mark's (2.30 p.m.), Cancer (2 p.m.), Metropolitan (2.30 p.m.), London Throat (9.30 a.m.), Royal Ear (3 p.m.), Samaritan (9.30 a.m. and 2.30 p.m.), Throat, Golden Square (9.30 a.m.), Soho Square (2 p.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," "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 WARNING.

OUR London readers should note that just at present the police are making active inquiries as to the whereabouts of a tall young man with a scar on his forehead, who is stealing things from consulting and waiting rooms. His plan is to call outside consulting hours and ask to be allowed to write a note for the medical man on his return.

**DR. T. (Lewisham).**—Speaking generally, one year's hospital training is absolutely inadequate to turn out a properly equipped nurse. Three years at least is necessary, and a still further experience of hospital life is requisite if she aspires to taking any of the posts including supervision in the larger institutions for the sick. It is just possible here and there that an individual case may demand exceptional treatment, as, for instance, when a nurse received her training in the days when a three years' course was not considered essential. It would be impossible, however, to give an opinion on any such instance without a full acquaintance with the facts of the case.

**THE DIMINISHING BIRTH-RATE.**—It is a fact that the Society of Medical Officers of Health were unable to come to a decision as to whether or not the declining birth-rate of the United Kingdom was due to "preventive" practice amongst married persons.

**F. B. C. S. (Birmingham)** writes us asking if any of our readers have known cases where gall-stones have been vomited. He has recently had under his care a patient who nearly died from exhaustion, &c. There was localised peritonitis and symptoms pointing to impacted gall-stone. She refused operation, but recovered ultimately after vomiting a large gall-stone. (For similar case see Jonathan Hutchinson's "Smaller Atlas of Clinical Illustrations," Plate lvii.—Ed. M.P. & C.)

**BRISTOLIENSIS.**—Diabetes insipidus has been met with occasionally in Raynaud's disease, and glycosuria more frequently, and in some instances the sugar appeared to be secondary to gangrene. Raynaud recorded an interesting case in the *Nouveau Dictionnaire*, 1872, in which he gave the probable sequence of events as several years of recurring local asphyxia, then diabetes, which brought on gangrene and tuberculosis. One of the best comprehensive accounts of Raynaud's disease with which we are acquainted is to be found in Munro's book, published in 1899 by Maclehoose and Sons, of Glasgow.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, SEPTEMBER 28th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (23 Chenies Street, W.C.).—4 p.m. Mr. T. P. Legge: Clinique. (Surgical.)

THURSDAY, SEPTEMBER 29th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (23 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.)

FRIDAY, SEPTEMBER 30th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (23 Chenies Street, W.C.).—4 p.m. Mr. R. Lake: Clinique. (Ear.)

## Vacancies.

Leicester Infirmary.—Assistant House Surgeon. Salary £80 per

annum, with board, apartments and washing. Applications to the Secretary, the Infirmary, Leicester.

West Riding of the County of York—Storthes Hall Asylum Kirkstall, near Huddersfield.—Assistant Medical Officer. Salary £140 per annum, with furnished rooms, board, attendance, and washing. Applications to the Medical Superintendent.

French Hospital and Dispensary, 172 Shaftesbury Avenue, W.C.—Resident Medical Officer. Salary £80 per annum with full board. Applications to the Secretary.

Ancoats Hospital, Manchester.—Resident House Physician. Salary £80 per annum, with board, residence, &c. Applications to Saml. Baron, Secretary.

The Manchester Northern (late Clinical) Hospital for Women and Children.—House Surgeon. Salary £80 per annum, with apartments and board. Applications to Mr. Hubert Teague, Secretary, 38 Barton Arcade, Manchester.

Central London Throat and Ear Hospital, Gray's Inn Road.—Second Assistant Anaesthetist. Honorary yearly appointment. Applications to be made before September 28th to Richard Kerhan, Secretary.

Royal Halifax Infirmary.—Third House Surgeon. Salary £80 per annum, with residence, board, and washing. Applications to Oates Williams, Secretary, Royal Halifax Infirmary, Halifax.

Northampton General Hospital.—House Surgeon. Salary £100 per annum, with furnished apartments, board, attendance, and washing. Applications to C. S. Biebee, Secretary-Superintendent.

Newcastle-upon-Tyne City Hospital for Infectious Diseases.—Resident Medical Officer. Salary £100 per annum, with board, lodging, &c. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

The Earlswood Asylum, Redhill (The National Training Home for the Feeble-minded).—Junior Assistant Medical Officer. Salary £120 per annum, with board, lodging, washing, &c. Applications to the Secretary, 36 King William Street, London Bridge, E.C.

Parish of Kensington.—Second Assistant Resident Medical Officer. Salary £80 per annum, with apartments, board, and washing. Applications to W. H. Stephens, Clerk to the Guardians, Marlow Road, Kensington, W.

## Appointments.

FELTON, WALTER B., L.R.C.P.L., L.R.C.S.I., Medical Officer and Public Vaccinator for the Newlyn East District by the St. Columb (Cornwall) Board of Guardians.

JOHNSON, W. CROSBY, M.B., Ch.B. (Vic), Honorary Physician to the Pendleton Branch Dispensary of Salford Royal Hospital.

RODGER, T. E., M.B., B.S. (Glasg.), Certifying Surgeon under the Factory Act for the Salford District of the County of Dumfries.

SIMPSON, THOMAS YOUNG, M.R.C.S., L.R.C.P. (Lond.), Junior House Surgeon at the Royal Albert Hospital, Devonport.

STYLL, F. W., M.R.C.S., L.R.C.P. (Lond.), Medical Officer for the Brest (Devon) and District Postal Staff.

## Births.

CHANCE.—On September 20th, at 90 Merrion Square, W., the wife of Arthur Chance, of a son.

## Marriages.

BOURNE—ROBERTS.—On September 21st, at Holy Trinity, Sittingbourne, Kent, Henry James Frederick Bourne, L.R.C.S., L.R.C.P., of Bridge House, Halling, Kent, eldest surviving son of the late Henry Bourne, of Antigua, W.I., and Redhill, Surrey, to Lillian Theodora, youngest daughter of the late Rev. W. Roberts, formerly vicar of Halling, Kent.

CARR—MORRIS.—On September 21st, at Shanghai Cathedral, Sydney H. Carr, M.D., son of the late T. W. Carr, of Newtown House, Carlisle, Cumberland, to S. Emmie Morris, Ovoca, Elliot Hill, Lewisham, London.

DALTON—BRINSLEY SHERIDAN.—On September 20th, at the Cathedral, Mullingar, by the Rev. R. A. O'Reilly, S.J., Clongowood (uncle to the bride), assisted by Rev. W. Egan, P.P., Mount Nugent; Rev. L. J. Condon, O.S.A., and Rev. Michael M'Sweeney, Cork, Richard Dalton, Esq., M.D., son of Garret Dalton, Esq., 68 Grand Parade, Cork, to Roseamond, youngest daughter of Richard Brinsley Sheridan, Esq., J.P., Lake View, Mount Nugent, co. Cavan. No cards.

STOCK—VAN BEEK.—On September 20th, at St. Peter's Cathedral, Pietermaritzburg, Natal, Phillip Graham Stock, Captain R.A.M.C., Assistant Medical Officer of Health, Johannesburg, youngest son of Granger Stock, Clifton, Bristol, to Ellen Elizabeth (Nellie), eldest daughter of Carl Van Beek, Esq., Johannesburg.

## Deaths.

ASHTON.—September 19th, at Marlborough Lawn, Cheltenham, Brigade Surgeon William Ashton, eldest son of the late William Ashton, Esq., of Donerail, co. Cork, aged 68.

CLARKE.—On September 20th, at 23 Lower Look Gardens, Brighton, Margaret Beatrice, widow of Vans Christian Clarke, M.D., B.N., aged 82.

FOSTER.—On September 21st, Mary Bound, the wife of Joseph Foster, M.D., of 10 St. George's Road, Eccleston Square, aged 61 years.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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## Original Communications.

### THE ISOLATION HOSPITAL.

By G. D. MARRIOTT, L.R.C.P., L.F.P.S. Glasg.,  
Medical Officer of Health, Borough of Nottingham.

THE isolation hospital is a preventive institution or nothing. If it fails to prevent it fails altogether. To imagine that it could remain as a nursing-home is to misapprehend the aim and object of such undertakings, and to lose sight of the financial considerations which are involved. The main purpose which they were intended to serve and the chief use to which they have been put was the aggregation of cases of scarlet fever. Attention has at last been compelled to the fact that the system cannot be justified in the face of notification returns, and we are now being asked to believe that such places are at least necessary for the better nursing of enteric and other cases. In other words, the isolation hospital, having failed as a means of prevention, is to survive as a pauperising institution—a state of things which would be as impossible as it would be absurd.

It has been said that the wholesale condemnation of the isolation hospital was at least a tactical blunder, that it would have been wiser to advocate the limitation of the scope of the proposed inquiry to scarlet fever isolation. But would it be possible to so limit it? I doubt it. It would be difficult, for instance, for a Royal or other Commission to exclude from its deliberations discussions dealing with the "isolation" of diphtheria and those borderland variants to which Dr. Biss has so ably called attention. Should it be proved, as we believe it will be, that "isolation" in both cases has been a gruesome mistake, there will be such an outcry in this country as will enforce a further inquiry into the consequences, both to the individual and the community, of the aggregation system generally. In my judgment such an inquiry, carried out from an authority from which, as Dr. Millard rightly suggests, all partisans should be excluded, could only end in one way—namely, in the complete abolition of a system which never had a ray of sanction either of science, experience, or common sense.

Let it be granted, for the sake of argument, that the result of the inquiry is a general condemnation, so far as the "isolation" of scarlet fever and diphtheria are concerned; what work, then, remains for the isolation hospital to do?

Thanks to sanitary betterment—and not to the aggregative system—we have got rid of

relapsing fever. If typhus has not yet entirely disappeared, it is because of the neglect of the most elementary precautions against a disease the *materies morbi* of which is not able to cross an open space. Enteric cases are successfully nursed in the common wards of general hospitals. Measles and whooping-cough, it is generally conceded, will never be made the subjects of experimental "isolation," as has been the case with scarlet fever. This leaves us only small-pox to deal with. I wish here to be as guarded as I always have been in my criticism of the small-pox hospital—an institution which is generally dissociated, as far as possible, from the ordinary isolation hospital. That the aggregation of small-pox cases is bad for the aggregated I never had any doubt. In the case of a disease the striking-distance of which is so great, removal in presence of the usual crowd must be regarded with suspicion, and is a fact which few would attempt to deny. Nor can the constant presence of the small-pox cab in the crowded thoroughfares of a city be looked upon with any degree of satisfaction. True it is also that the removal of the first case does not always—it would be correct, probably, to say does not often—prevent the spread of the disease either in the home or in the locality. The safeguard here, as we all know, is vaccination. In vaccination we have a means of prevention which transcends in importance every system of "isolation" that has ever been devised, and without which no system could succeed at all. It is surely, then, more reasonable, and more scientific, to insist on the passing of a Re-vaccination Bill than to advocate the covering of the earth with small-pox hospitals. In this connection it will not have escaped the notice of the profession that the medical officer of health of this city has been recently successfully treating small-pox cases in what was practically the open air—cases which he despaired of getting well if left in the wards of the small-pox hospital. Dr. Bobbyer's reading of these happenings may not chime with mine; probably it does not, but the fact is generally interesting, and to me significant.

Since the passing of the Public Health Bill almost the sole conception of disease-prevention has been the erection and crowding of so-called up-to-date and well-equipped "isolation" hospitals. Monies that ought to have been devoted to works of sanitation, which is to say disease-prevention, have been squandered on experimentation. In spite of the generally recognised impossibility of obtaining any data on which such a claim could be based, medical

politicians, such as Sir Walter Foster, have been declaring that, but for such institutions the population of these islands would have been long ere this decimated and our civilisation destroyed; and lamenting that the whole municipal debt of three hundred millions had not been incurred in the establishment of isolation hospitals. While leading politicians who are members of our profession talk like this, can it be wondered at that others in less exalted positions have persuaded themselves that they can settle these important questions with a wave of the hand, or that an enlightened, though not converted, section of the medical press should give such grudging assent to what it is no longer able to ignore?

Now one word of warning. It is probable that the value of the "isolation" hospital is now about to be appraised. Let us hasten slowly! It is inconceivable that any greater mistake could be made than to hurry the thing forward. The question is ripe for discussion among ourselves—it is not yet ripe for an inquiry by Royal Commission. Truth is truth to the end of the reckoning, and there is nothing to fear from free discussion, but much to fear from undue haste.

## PARAFFIN IN PLASTIC SURGERY. (a)

By STEPHEN PAGET, F.R.C.S.,  
Surgeon, West London Hospital, &c.

THE author stated he had injected paraffin in about seventy cases of depressed nose and ten of prolapse of the rectum or vagina. For the nose cases, he used a paraffin melting at 114° or 115°F., prepared by Rogers, 327 Oxford Street, London, and a syringe made by Dröll, of Frankfort, recommended by Dr. Stein, of Wiesbaden. In these nose cases it was of the utmost importance not to attempt too much, but to be content with the least improvement that would content the patient. Those cases were most favourable where the skin was loose, free, soft, and healthy, and the tip of the nose was well-formed and in the middle line. Those cases were less favourable where the skin was rigid or shrunk. And those were wholly unfavourable where the skin was scarred, adherent, pinned-down to the deeper structures, and wasted. Everything depended on the state of the skin; if that was favourable, it did not matter if the septum were perforated. He had not had any case of embolism or sloughing, and he believed that these dangers might always be avoided; the more common danger was that of attempting too much. The least excess of paraffin impaired the result of the injection, and the surgeon ought to attempt nothing more than just to make the patient unnoticeable. He advised that a general anæsthetic should be given; that gentle pressure should be continued for ten or fifteen minutes after the injection, till the paraffin was perfectly rigid, and that a cold wet compress should be laid over the upper part of the face for a day or two. No sort of nasal splint was of any use.

Of the cases of prolapse of the rectum or vagina, treated by injection of paraffin under the mucous membrane, two had relapsed, and in one the injection had been followed after some months by a

stricture of the rectum; but the majority of the cases had been successful, and the injection would avail even in cases where numerous operations had failed. In these cases of prolapse, the purpose of the injection was to strengthen and thicken and approximate the walls of the cavity, and thereby to hold up the slack redundant mucous membrane, and prevent its eversion. A paraffin melting at 104° or 105° was hard enough. It must be injected immediately under the mucous membrane, into the loose submucous tissue, and no deeper. In prolapse of the rectum, two or more nodules or hummocks of paraffin should be raised, in the lower two inches of the rectum, just under the mucous membrane; these being apposed would tend to prevent prolapse and leakage, but could not hinder the natural action of the bowels, and a good result might be obtained, even though the sphincters were destroyed or useless. In prolapse of the vagina a patient might be enabled to do without a pessary, or, at least, might be kept from prolapse by paraffin plus a pessary, though the pessary alone had been useless. But, of course, a cystocele or a very bad prolapse of the vagina was not easily cured, especially if the patient had to work hard for her living.

## Austrian Clinical Lectures.

### ON COLOUR HEARING.

By Professor HEINRICH CHALUPECKY, M.D.,  
Docent-Chair of Medicine, University of Prague.

[FROM OUR VIENNA CORRESPONDENT.]

IN reviewing our knowledge on this speculative phenomenon of the doubling of human sensations, the lecturer said that it would be instructive to examine more minutely the different theories advanced on the subject. The first of these views is given by Nuel under the title of "Central Irradiation," wherein he contends that the explanation of the double sense of sound and colour, or sound-producing colour, is due to the proximity of the hearing and seeing centres with a disposition to hypersensibility. This sensitive state permits of a stimulus acting on one to pass over to the neighbouring centre, and act on the second centre with a positive result in either colour or sound.

Steinbrugge's view of the phenomenon is that the nerves conveying sound and sight lie in close communion with one another, so that the stimulus, passing along the communication, is transmitted equally to each centre with the double result—i.e., one peripheral stimulus produces both hearing and seeing.

Thorp thinks the confusion of colour and hearing is intra-cerebral where fine fibres connect the acoustic with the optic nerve.

Now the objection to these three theories is that the principle does not apply to all cases. To the first it is objected to on the ground that the cortex is in connection with all the other centres; how, therefore, disposition can affect two centres is difficult to comprehend. This same objection applies to the second theory. Pedrono raises a similar objection to the third. These aberrant fibres referred to are common in the brain between organs of sense where no such anomaly exists.

Urbantschitsch has recently applied himself experimentally to discover the real connection, and finally concludes that the phenomenon is a reflex

(a) Abstract of Paper read at the Oxford meeting of the British Medical Association.



action. He found that by applying equal stimuli—*i.e.*, strong light and loud sounds—similar results could be produced. Again, if strong light were applied to the eyes for some time the auditory nerve became tired and dull, and *vice versa*. Another of the experiments conducted was with a grey surface slightly undulating, on which the patient looked, and near to this surface was a tuning-fork. On continuing the gaze after the tuning-fork was sounded the patient could see red and yellow lines on the grey surface, and finally all the rays of the spectrum appeared to him. This interesting experiment does not prove the double sensation, but when we find the retina exhausted by the effect of sound, we must conclude that the stimulus has a very close connection with the auditory apparatus. Here again we must distinguish between retinal exhaustion and retinal disturbance. By intense gazing at any object the blood-vessels of the retina can be so altered that chromatopsia is induced—*i.e.*, colours, rings, &c.—simply by the muscles of the eye checking the free circulation of the blood through the finer structure of the eye-ball.

It may be noted here that these are the more recent opinions on the subject, which are not a great deal in advance of the older ones. In 1848 Cornaz observed that an increased colour sensation was the anti-analogue of colour-blindness. At a later period Marcé adopted a scale of hyperchromatopsia which more recently has been developed by Albertoni in connection with a modulated scale of sounds which had been acknowledged as defective in the earlier experiment, as it is frequently observed that the patient who could not distinguish colours very well was as bad at recognising or distinguishing notes in a scale of sounds. This led to the establishment of a scientific scale of corresponding sounds that were defective in the colour-blind patient. It was found by observation that red-blind patients could not distinguish the G tone, while green-blind were unable to differentiate the D sound, which were fixed at Hauth's scale, and subsequently extended to G, E, C, and followed in the spectrum to C, D. Preyer deduced another on this same basis by light and vibrations. He found that the tone C produced a brown colour, and the tone D a red colour. In the same way he found E to be orange, F yellow, G green, A blue and B violet. With the assistance of the Italian School of Harmony, he endeavoured to elaborate this scale still further by combining colours, such as red-green and violet, and in harmony with D, G, B. At a later period, Castel combined these two systems, which now form one under his name. Notwithstanding all this scientific parade, we are still without the real cause of colour-blindness, unless we infer from these observations of sound and light that both organs of sense were defective. Beyond this deduction, no theory of the production can be formulated to account for the phenomena, and we are thus forced to look in some other direction for a better explanation.

The theory of evolution is found to be more satisfactory to the speculative mind. In the lower animals one nerve centre has all the functional activity of the differentiated brain of the higher animals. Thus it is argued, where a double sensation exists the brain is not fully developed, or has not reached the normal standard of evolution. It is well known in practice that these malformations are hereditary, and that double sensations of hearing and seeing are atavistic in character. This

argument would be perfectly easy and lucid if Hilbert would not disturb the calm repose with an awkward question: How is it that this acoustic-photoism often occurs in the short interval of waking and sleeping? Does the stimulus excite two senses—hearing and seeing—after consciousness is lost? He is inclined to interpret this phenomena in a different manner, and thinks the sensitive condition of sound-producing colour mostly belongs to the young, to disappear as years roll on; hence senile decay is what we have been prone to call the normal state of the brain, which, according to this reasoning, is only senile involution of the organism.

After reviewing such diverse opinions, one is driven to the conclusion that the double sensation is only an exalted condition of the entire cortex of the brain, or, in other words, due to cortical hyperæsthesia, and the best explanation after all our efforts may be found in the clinical experiment of Cololian and Rodiet, who produced cortical hyperæsthesia with alcohol, whose acute stage produces many hallucinations. With these patients it is no uncommon thing to produce in any two of the special senses the opposite effect. By percussing the surface of the body the alcoholic can often hear someone talking, or see different colours. Reasoning in this way, one is inclined to ask himself if this double sensation of light-producing sound is another form of hallucination, when all the senses can be taken in detail. It seems that hallucinations are the product of irritated nerve centres, which may be simply from irritating the centre itself, such as with the toxic alcohol, or the stimulus produce a similar result; hence we may have either central or peripheral stimuli producing the same result. Absinthe and haschisch are still more excitant or epileptic in their action than alcohol. The latter being an Arabian extract of cannabis indica, and a stimulant which Gautier tells us that he drank himself to produce colour tones, which he describes as red, green, blue, and yellow, which he could perceive in distinct waves with different sounds. In another part of his work he tells us that the playing of a piano made such a noise that certain of the notes felt to him as arrows piercing his heart, while the other tones were blue, red, &c. Baudelaire, the poet, had the misfortune of indulging in haschisch, and taste and smell are associated with colour and tones, which he makes free use of in his poetry.

There are other well-known toxins, such as san-tonin, which at first produce xanthopsia, followed by a violet colour-blindness, burning of the skin, and finally a dull insensible feeling—*i.e.*, first hyperæsthesia followed by anæsthesia.

With these facts before us we have only to imagine a cortical hyperæsthesia of a congenital nature, and we obtain all the factors necessary to produce sound-photopsia or aberration of the other senses. Our famous painters, poets, musicians and mechanics belong to this class of cerebral deviations. This sound-stimulus producing colour is well marked in the poet Binet, whose verse is crowded with "coloured spectra" which he tells us were produced by the strains of music. We may therefore conclude that all these elaborate theories of proximity of centres on nerve fibre connections with central ganglia, and nerve heredity, or atavism are speculations of a very abstruse nature and not at all borne out by pathology or physiology. Sound-hearing may be defined as a physiological deviation of the cortex which, if weakened, over-

worked or stimulated into a condition of hyperaesthesia, feeble stimuli are sufficient to produce abnormal physiological results.

## THE EVOLUTION OF THE SANATORIUM TREATMENT OF CONSUMPTION, (a)

By T. N. KELYNACK, M.D., M.R.C.P.,

Physician to the Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Northwood.

GENTLEMEN,—The so-called "open-air" treatment of consumption has been subjected to what a vulgar public is accustomed to approve as the gentle art of "booming." At first discountenanced and ridiculed, it has rapidly grown in favour both with the profession and the public. But an injudicious optimism on the part of the laity, and an ill-judged and unqualified advocacy of some members of the medical profession, have not unnaturally tended to turn the tide of unlimited hopefulness, and with the ebb of an irrational enthusiasm there is a real danger that the true place of the sanatorium in the arrest and alleviation of pulmonary tuberculosis may not be properly apprehended and much of the principles and no little of the practice of regulated hygienic treatment of consumption be discountenanced and neglected.

It cannot be denied that much disappointment has resulted in many quarters in consequence of the failure of the open-air treatment to fulfil all the miracles of healing which unscientific enthusiasts claimed for it. The new treatment, as it is still sometimes designated, has been advertised and exploited as though it possessed specific therapeutic properties. And in the upspringing of institutions professing to provide rational hygienic treatment of consumption it must be admitted that establishments have come into being the conduct of which has not gone to encourage faith or develop practice in a systematic and scientific management of the disease.

Undoubtedly in the rational application of hygienic methods we have the most effective means known to medical art of combating pulmonary tuberculosis, and it will be lamentable if, through lack of judgment, insufficiency of knowledge, or selfishness, the pendulum of public and professional opinion be allowed to swing back from its position of illogical and unscientific hopefulness to a position of equally illogical and unscientific hopeless despair, when by a clear statement of the true position as evidenced by pathological research and clinical experience an attitude of mind can be reached which is willing to prove all things and hold fast to that which is clearly demonstrated to be good.

Having studied the development of the sanatorium movement in this country and visited most of these institutions in Great Britain and Ireland devoted to the management of consumptive cases, I venture, in the short time allotted to me, to endeavour to place before you the main features in the evolution of the modern sanatorium for the treatment of consumption, to indicate somewhat of the nature of the present practice followed, and to forecast something in regard to the future.

(a) A Lecture delivered at the Post-Graduates' College and Polytechnic, London, on Tuesday, July 5th, 1904.

### THE GROWTH OF HYGIENIC TREATMENT.

Every healthy man is slow to realise the advantages which accrue from a regulation of his life in accordance with hygienic principles. The need for public sanitation he readily admits, but the practice of personal hygiene he willingly neglects. It is easily understood, therefore, how difficult it has been to make the average mind realise that hygienic methods were all-important in the management of the morbid, and especially in such a disease as pulmonary tuberculosis.

There seems to be a general idea that our views and practice in regard to the hygienic treatment of consumption were made in Germany; but, whilst we willingly bear witness to the directing and inspiring influence of Brähler, Dettweiler, Walther, and others, it is but right that we should accord due honour to English and American pioneers.

[Quotations were here given from the writings of such pioneers as George Bodington, Henry MacCormac, Parrish, and Benjamin Ward Richardson.]

### THE SANATORIUM OF TO-DAY.

Interesting and instructive as it is to consider the development of what we may term the sanatorium idea, it is more important to investigate the principles which underlie the institutional treatment in the present and study the methods employed in the various establishments which now stud the country.

Sanatoria now exist for all sorts and conditions of sufferers. The wealthy may enjoy many of the luxuries of hotel or club life, while the pauper can at least be supplied with the inexpensive necessities of fresh air and exercise. And it is well that provision should be made for patients drawn from every rank of life, for consumption is no respecter of position. But it is most necessary, if the method is not to fall into disrepute, that the essential principles of the hygienic treatment be insisted on, and the method of their application directed by medical authority.

At present there exists the widest diversity. Some sanatoria are conducted in accordance with a slavish imitation of the so-called "Nordrach system," and procedures are insisted on ill-suited to the character and constitution of most British patients.

In certain institutions there is the greatest laxity, patients being left to order, in great measure, their own manner of life, and receiving but little better attention than residents in a convalescent home. Several so-called sanatoria exist where there is no resident medical officer, and in not a few the chief work devolves upon a recently qualified junior and necessarily more or less inexperienced resident. A number of lady medicals are taking up sanatorium management. A considerable number of those responsible for the medical conduct of sanatoria have themselves been the subjects of phthisis, and not a few have come under the influence of the masterful personality of Walther at Nordrach. With some of these there would sometimes seem to be a tendency to elaborateness of details and all-pervasive supervision which is liable to rob the patient of all originality and initiative, and undoubtedly sometimes go far to develop neurotic characteristics. Wide differences also exist in regard to nursing in sanatoria. Those who follow the Continental methods of procedure discountenance the presence of the trained nurse, and some even disallow

attendants to wear anything resembling a nurse's garb. It is undoubtedly well that patients should be prevented from falling into habits of selfishness and encouraged to do for themselves such matters as will not interfere with their restoration to health, and those patients belonging to the working classes should be expected to assist in actual work as far as their condition will allow. But we believe that a well-trained nurse is most desirable, not only for the carrying out of rational therapeutic measures, but also for the maintenance of what we may term the educational atmosphere of sanatorium life.

Much discussion has taken place regarding the structural form and situation of sanatoria. These establishments present remarkable contrasts. Some are almost palatial in their design, lavish in their equipment, extravagant in their upkeep, and such as can only be brought within the means of the wealthy. Others are simple in construction, bare and comfortless in their fittings, inexpensive in their conduct, and intended for the comparatively poor. Many are admirably placed in sunny and protected regions, while not a few are situated on exposed, damp, windswept sites. But the remarkable fact comes out clearly that while some cases do well under the simplest, and it may be seemingly most unfavourable, conditions, others, even when placed in what theoretically should be the most advantageous life, do ill.

#### PRINCIPLES OF SANATORIUM TREATMENT.

But however widely sanatoria may differ in the details of procedure, it is most desirable that the general principles guiding action should be similar.

In selecting a suitable case for sanatorium treatment it is well to remember that hygienic management seeks to secure :

I. The removal of the patient from fresh invasion by the tubercle bacillus, and separation, as far as possible, from all influences aiding its introduction.

II. The establishment in the patient of processes of repair and the development of the highest powers of resistance.

To this end the instruments employed are :

1. Continuous exposure to fresh air.
2. Free access to sunlight.
3. Regulated rest.
4. Controlled exercise.
5. Abundant feeding.
6. Obedience to hygienic requirements.
7. Strict medical supervision.

I cannot stay now to explain the manner of action of these various factors, but they should be employed with a clear apprehension of their physiological influence and therapeutic value. Unfortunately, at the present time too much in sanatorium treatment is lacking in scientific precision and savours too much of mere empiricism.

And such a state of affairs is likely to persist so long as discordant views prevail regarding the pathology of pulmonary tuberculosis and widely divergent views are promulgated regarding its origin, spread, arrest, and prevention.

It is much to be regretted that so little is being done in the sanatoria of this country to encourage systematic scientific research.

It is well that we should remember that much connected with the so-called hygienic management of consumption is at present in little more than the experimental stage.

#### SELECTION OF CASES FOR SANATORIUM TREATMENT.

There is need for the greatest care and the most judicious discrimination in selecting cases for sanatorium treatment.

Too often resort to open-air treatment is advised as though it possessed the virtue of a definite specific. In many instances patients are sent by their medical advisers to sanatoria as a last resort. By a reckless advocacy of institutional treatment much harm is being done to many an individual, and public sympathy and support are in danger of being discouraged and even alienated.

All cases of consumption should no doubt be treated in accordance with strict hygienic principles, and generally speaking the best hygienic management can only be provided in properly constructed and well-conducted sanatoria. But at the present time with the limited accommodation available for the indigent and those of limited means it is most desirable that there should be a wise selection of cases. This is abundantly clear when we remember that in England and Wales alone considerably more than 40,000 deaths are registered every year from phthisis, and that between the ages of fifteen and twenty-five one-fourth of the total deaths are due to this disease.

But prognosis in pulmonary tuberculosis is beset with difficulties. Many of the old precepts have ceased to have directing value. The pessimism of past days has given place amongst not a few to an optimism which unfortunately is oftentimes groundless. It is sometimes claimed that phthisis is the most curable of chronic infective diseases, and while pathological evidence and clinical experience go far to afford basis for such an opinion, yet I am convinced that we should always do best to regard phthisis in all its forms as a most grave malady. Many cases certainly do arrive at a complete arrest of the pathological process, but among the poor and working classes quiescence is often only temporary, and relapse, re-infection or a re-awakening of the slumbering ill only too commonly occurs.

Hygienic treatment may accomplish much. It undoubtedly affords the most scientific and the most successful means for a rational combat with consumption. But the powers of the open-air treatment are limited, and it is detrimental both for the individual and the charitable public to make claims which experience cannot support.

We must view the prognosis of phthisis in the light of present-day knowledge and submit every case to individual study before advising resort to what may be an expensive and ultimately useless institutional control.

[The various points guiding prognosis in cases of phthisis were then discussed and indications given for judicious selection of cases for sanatorium treatment.]

#### THE FUTURE OF THE HYGIENIC TREATMENT OF CONSUMPTION

As I have already indicated, the so-called hygienic treatment of consumption undoubtedly affords the most trustworthy and successful means for dealing with tuberculous cases. It is, of course, possible that medical science may discover some method whereby a special serum or other body may provide prophylactic powers or act as a definite antitoxin, and so necessitate a modification in our institutional treatment.

Meanwhile much may be done to extend and amplify the application of such hygienic measures as clinical experience has shown are rich not only in preventive force but also effectual, to a great extent, as curative and alleviative agents.

From what I have said regarding the necessity for a careful selection of cases, it is clear that much remains to be accomplished in the way of a more precise differentiation in the grouping of patients.

It is most undesirable that so-called incipient cases should be allowed, as is now so often the case, to associate with persons in an advanced stage.

Institutions located in or near our large centres of population should be used mainly for advanced cases and for the purpose of observation of those in which prognosis is doubtful.

Cases in which arrest is at all possible should at once be given the opportunities of a country sanatorium, which, particularly in the case of the poor, should not be difficult of access from centres of work.

There is great need at the present time for suitable homes for those helpless and hopeless cases occurring among the poor and labouring classes, for whom there is now practically no refuge save the much-dreaded workhouse.

Undoubtedly the action of most general hospitals, special hospitals for consumption and sanatoria, in refusing admission to all manifestly hopeless cases necessitates the retention of large numbers of dying phthisical patients in homes devoid of all hygienic requirements and such as facilitate infection of relatives and friends, many of whom are often peculiarly predisposed to contract the disease.

Efficient sanatorium treatment, it must be remembered, can never be inexpensive. Means must, however, be found for dealing with the immense number of those who, self-supporting whilst in health, when smitten by disease are compelled to join the ranks of the dependent. At the present time there is abundant sanatorium accommodation for the well-to-do. Much is also being done to meet the requirements of the poor, but for sufferers belonging to the struggling professional and business classes adequate opportunities for hygienic treatment are few and far between.

Much will also have to be done in providing for satisfactory "after care." Only too frequently a patient who has done well during residence in a sanatorium speedily relapses because, in the absence of systematised means to secure suitable work and a hygienic dwelling, he or she is compelled to return to the old occupation and the former insanitary mode of life; and thus time, skill, and money are expended in vain and a desirable form of treatment is brought into disrepute.

I am afraid that in this country there is at the present time but little chance of national friendly societies and labour organisations rendering much assistance in the establishment and maintenance of sanatoria for the working classes, after the manner adopted in Germany. Much may be said in favour of the suggestion to hand over London consumptives to the care of the Metropolitan Asylums Board.

I am also of opinion that some of the many convalescent homes which abound in this country might well be devoted to the further up-building of

those who have passed through our public sanatoria, where, it must be remembered, the patient can usually only be retained for a comparatively short period, long enough, it is true, to teach the necessity for and the best means of maintaining the hygienic life, but oftentimes quite inadequate to procure anything approaching a complete arrest of the tuberculous process.

I do not propose to discuss the advantages and disadvantages of compulsory notification in relation to any public system of sanatoria. A voluntary notification is in force in many important centres, and it is clear that reliable information regarding the presence of tuberculous subjects and the conditions under which they have fallen ill and the arrangements for their relief and treatment would be of the greatest service if wisely used not only for the safety of the State but the benefit of the individual sufferers. It is very necessary, however, to bear in mind constantly that among many persons in all ranks of life there exists an unreasonable, and I think I may safely add an unwarranted, fear of any association with the phthisical, and as is well known already in America this phthisiophobia has much increased the difficulties in founding and maintaining sanatoria and otherwise adequately dealing with the consumptive.

Gentlemen, it is well, if we would retain the confidence of the public and maintain the dignity of our profession, that we should readily admit that we are still far from a clear understanding of the nature of the disease we term pulmonary tuberculosis.

Treatment still lingers for reliable direction from pathology.

We have in great measure shaken free from the trammels of many erroneous views, but we are still to a large extent groping in doubt and uncertainty.

Sanatorium treatment has accomplished much, and I believe is destined to have far reaching influence, not only in bringing benefit to the individual sufferer, but in making clear to the public the advantages of the hygienic life.

But we must be willing to admit that much connected with the so-called hygienic treatment of consumption is still in the experimental stage.

Let us therefore continue to maintain the truly scientific attitude; and while extending a critical sympathy let us, with the true insight of the rational therapist and the far-seeing wisdom of the sanitarian, remember that the modern sanatorium for the consumptive is still in process of being.

### Clinical Records.

#### HEMIANÆSTHESIA AND CONSCIOUS TROUBLES OF SENSIBILITY IN SLIGHT AND OLD HEMIPLEGIA.

By G. A. SCHERB,

Assistant-Professor to the Medical School; Consulting Physician to the Mustapha Hospital, Algiers.

PROFESSOR O. MARIE, my distinguished master, once asked whether, in the case of a hemiplegic, a well-marked organic hemianæsthesia could last for years.

In 1898, MM. Degerine and Long reported to the Society of Biology of Paris that, as the result of numerous microscopic researches in seriated sections, clear cases of sensory troubles, persisting

until death, occur among hemiplegics. (a) The condition may exist many years after the initial "stroke," even though the motor troubles have considerably diminished. They have pointed out that a slight lesion accompanied with trifling motor troubles involving the external part of the thalamus was likely to bring about an obstinate hemianæsthesia by destroying that grey substance which constitutes a relay or a stage between the ascending peduncular ways and the thalamo-cortical fibres. One understands, under these circumstances, the possible existence of a more intense and lasting hemianæsthesia than the concomitant hemiplegia, by reason of the sensitive ducts being here still, as in the *calotte's* region, more or less distinct from the motor paths.

MM. De erine and Egger (1903) have, besides, recently reported a case absolutely confirmatory of those views, which were rather novel and opposed to the classic teaching of Charcot, who always said that the lower part of the internal capsule contains, still isolated, the sensitive bundle. This is what induces me to state the particulars of the following case, carefully recorded by M. De Mouzon, an outdoor student attached to my wards of the Mustapha Hospital:—

D., æt. 49, farm labourer, native of La Lozère, a short but thick-set and vigorous highlander, had a fall, eight years ago, from a height of about two metres into a vat. Owing to his having been unconscious, he could not give any information as to the cause of his fall, nor could he say what part of his body was hurt. This point is of importance, both from the diagnostic and the forensic point of view. Now, suppose that man believed himself hurt and crippled in the course of his work, there would be great reservations to be made, for one should put oneself the question whether there had not been a previous ictus which had determined the fall. He did not know why or how he fell, and, as he came to about half an hour afterwards—that is, when his mates took him out of the vat—he had no sore on the head nor any indication whatever of a trauma of the skull. However, he kept his bed for twenty days, for he could not move the right side of his body. His speech was not at all affected, and his face only bore slight traces of motor troubles, which have persisted up to now. At the end of those twenty days he could make a few steps, and he walks to-day almost normally, and he must be attentively observed to perceive that in walking he drags his right leg slightly. Thus he shows Babinski's sign on the right side by pricking the right sole, with exaltation of the patellar reflex and of the wrist. If he tries to whistle, there is a deviation of the left side of his mouth, and he whistles badly; if he puffs up his cheeks by obliterating his lips, the right labial commissura appears incompetent directly. No muscular atrophy exists, and Mr. Bordet, a friend of mine, who has submitted him to an electro-diagnosis of the shoulder muscles, where the motor deficiency is most marked, has found normal electric reactions. However, the patient does not cease to complain that his motions on the right are impeded. No noticeable weakening of the muscular strength was evident on the right side, but that strength is somewhat transient; it exhausts itself quickly; he is unequal to any continuous effort. Moreover, he cannot raise his right arm above his head

—on account of the peri-arthritis, no doubt—and he suffers from his right shoulder if he ventures to raise his right arm above the horizontal line. Obviously hypertrophied is the right hand, and that uniformly. That constitutes the trophic troubles which are the first indications of that hypertrophied hand that one sometimes meets with in the case of hemiplegia. No deviation at all of the vertebral column. The pupils are even and the eyesight is not impaired, no shortening of the visual field has taken place, while olfaction, hearing and taste have remained normal. And there is not any hysterical stigma.

From the first day my attention has been drawn by the sensitive deficiency. I have had this case under observation for a year and it has not varied. Besides, the patient himself is aware of it all; the first remark he made when he began using his right hand was that he did not feel the heat of the bowl of his pipe. The sensitive troubles have in the study thereof been serial; upon the whole—and that is also the rule in organic anæsthesia proceeding from a cerebral lesion—they are prominent chiefly at the extremities of the limbs.

*Brush Examination.*—Right sided hemianæsthesia. In the upper limb, the troubles predominate at the hand and by degrees diminish at the elbow and arm, only to increase again at the level of the shoulder. The foot is almost entirely anæsthetic, the leg and the thigh are rather less. The trunk and the face are hyperæsthetic on the right, and the mucous sensibility of the mouth on the same side is impaired.

*Pressure Sensation.*—Considerable difference exists between the faculty of the left side and that of the right.

*Sensibility to Pricking.*—Same observations as in examination of tactile feelings.

*Thermæsthesia.*—Considerable reduction in the extremities, with delay or slowness in perception. With regard to cold, however, there is no lack of sensitiveness in this direction. Experiments have been made with ice and a hammer heated in boiling water. It is to be noted that the right shoulder region shows a dull sensibility to temperatures which the hand fails to perceive.

*Perception of Passive Segmentary Attitudes.*—The attitudes imparted to various segments of the right upper limb are not altogether lost. Now, as for flexion, supination, abduction, pronation, &c. Let the right arm of the patient be placed in a certain position; he cannot place his left arm in a similar position if he shuts his eyes. In trying to do so, slowness and groping uncertainty prevail.

In the lower limbs motions are well performed.

*Stereognostic Sense.*—Almost absolute disappearance in the right hand. Moreover, if, without the control of his eyesight you give an ordinary glass to the patient to weigh, he directly values the weight thereof at 2 kilogrammes. Most gross mistakes of weight of this kind are made about very common things. He does not know them by feeling them, and he is incapable of valuing their weight.

*Conclusions.*—It is evident that there are to be found all the attributes of organic hemianæsthesia through lesion of the encephalon. These troubles are fixed and conscious, dating from about eight years back, without any change; they are not, however, accompanied by hemianopsia, and motor disturbances are very slight indeed. Still, it is on the right shoulder that they predominate on account of some ankylosing arthritis; the most

(a) "Traité de Médecine" de Brouardel et Gilbert. T. viii.

profound troubles of sensibility lie in the perimeter of the scapular region, on account, undoubtedly, of the fact that it is there the sensory re-education could less easily be made, owing to the fact of restricted motions. Nevertheless, it must be insisted upon that the shoulder troubles do not in the least affect any metameric disposition.

Thus it is exceedingly probable that in the case of D. the matter is one of a very slight lesion of the thalamus in its external and posterior part, as the motor deficiency is, indeed, so little developed. That lesion, if extended backward, would have resulted in hemianopsia; if, on the contrary, forward laterally, these motor troubles would have been more serious.

A solely lenticular or capsular limited lesion would not have been accompanied by sensory troubles so deep and persistent. This case is one to study carefully from a clinical point of view. It comes absolutely within the range of these sensory definitive posthemiplegic troubles of which MM. Dejerine and Long try to fix the anatomical substratum.

### The Out-Patient Departments.

*Dermatological Cases under the care of Dr. P. S. ABRAHAM.*  
[REPORTED BY DR. G. N. MEACHEN.]

CASE I.—*Extra-Genital Chancre from a Bite.*—A single man, æt. 29, a stall-holder, came with an obstinate sore upon the back of his right hand. The history was that he was engaged in a fracas with his brother on the night of May 30th. This latter individual was in a state of intoxication, and was known to be suffering from syphilis. In the course of a struggle, the patient was bitten by his antagonist upon the back of the right hand. He did not take much notice of the occurrence at the time, but the spot remained somewhat inflamed for some time afterwards. At the expiration of a month he observed a distinct sore place over his knuckle and some painful lumps appeared under his arm. When seen, on August 26th, 1904, there was an oval, ulcerated sore,  $1\frac{1}{2}$  inch in its longest diameter, situated upon the dorsum of the right metacarpophalangeal joint. The edges were raised and infiltrated, and the surface was raw and discharging ichorous matter. About one inch behind it was another sore, one-quarter the size, and of a punched-out appearance. The axillary glands were enlarged. A typical secondary eruption of the scaly, maculo-papular type was present upon the body and limbs, which the patient stated had appeared soon after the sore. Seven weeks ago the throat was troublesome, and the original sore began to spread and to ulcerate. On examination, the fauces did not present any abnormal appearance. He had not had any medical treatment.

The history of accidental inoculation in this case was perfectly clear, but even if this had not been so, the raised and infiltrated character of the lesions upon the hand with their serous exudation would have been quite sufficient to form a diagnosis, without asking any further questions or examining any other part of the body. The multiplicity of primary chancres was not so uncommon as was generally supposed, particularly when the lesions were extra-genital.

The patient was at once put upon vigorous anti-syphilitic treatment.

CASE II.—*Extensive Tinea Circinata.*—A married man, æt. 41, presented himself for treatment with an eruption extending almost completely round his neck, which he had noticed for the last three months. He believed he contracted it at a barber's shop. On examination, a collar-like rash could be seen of a dark red colour and with a raised margin forming a ring practically all round the neck. The borders were slightly scaly, and here and there the more central parts appeared to be clearing up. The nuchal and occipital regions were the most affected, but the disease

had not encroached upon the scalp. Patches of a similar nature were also seen in the left ante-cubital space and upon the extensor surface of the right elbow. There was no inflammatory reaction nor pustulation of the surface. A scraping from the border of the patches upon the neck examined in liquor potassæ revealed an abundance of mycelium.

The comparative rarity of *tinea circinata* spreading in a collar fashion round the neck was commented upon. Extensive areas of ringworm of the body were, however, frequently seen in the groins and thighs, sometimes mounting upwards upon the abdomen. The so-called "*eczema marginatum*," applied to these eruptions was not a bad clinical term, though they had nothing whatever to do with true eczema. They were frequently mistaken for seborrhœic dermatitis. It was important in all cases to take a surface-scraping, for in this way only was a correct diagnosis possible.

This man was given an ointment containing half a drachm each of carbolic and salicylic acids to the ounce of vaseline.

## British Health Resorts.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

### XIII.—CHAGFORD.

DARTMOOR has long fascinated the favoured few and closely held the allegiance of artist and antiquary, sportsman and naturalist. (a)

Its topographical features and climatic conditions well fit it as a desirable upland health station. With the coming of rational ideas regarding the prophylactic and curative value of the hygienic treatment of the human subject, the advantages of this tableland region of Devon should become well known. (b)

The rampart is high and the average temperature low. Penetrating mists are very prevalent, but appear to exercise a soothing influence on many cases subject to certain laryngeal and respiratory affections. Severe frosts are experienced in winter, and the bracing character of the air is highly beneficial for many cases able to undergo active exercise in the open. Much cloud prevails at all times of the year, and lessens radiation from the ground.

Among the many centres bordering on Dartmoor which might well be developed into sanatoria, Chagford merits a foremost place. It lies at an altitude of 650 feet above sea level, well sheltered amid the hills on the north-eastern slopes of Dartmoor. The scenery is varied, and highland, lowland and woodland are all close at hand. The pedestrian has almost numberless walks of peculiar attractiveness, the invalid can quietly enjoy the benefits of salubrious air and bracing breezes, the feeble, contemplative, or invalid can find peaceful sport on the banks of the Teign, while the antiquarian and naturalist will find ample material for fascinating study. In short, the district is rich in natural health-giving features, and mind-stimulating characteristics, so that both physical and psychological influences can be combined in the treatment of disease.

We have resided at Chagford during summer days and thoroughly investigated the neighbourhood, and consider it an almost ideal country station for the overworked and brain-fagged. It should prove a perfect holiday resort for those who find in inland uplands restorative properties. For certain phthisical cases it offers admirable opportunities for open-air treatment. An excellent private sanatorium above the village of Chagford is already doing much good work, as we have been able to ascertain from personal inspection.

The district is not well suited to heart cases, and some patients will find the air too bracing, and during winter months the exposure too severe.

(a) See such a classic work as "*A Perambulation of the Antient and Royal Forest of Dartmoor.*" By the late Samuel Rowe, M.A. Third Edition, 1902. Consult also "*A Hundred Years on Dartmoor.*" By William Crossing. Fifth Edition, 1902.

(b) See "*Dartmoor and its Surroundings.*" By Beatrix F. Crosswell. Third Edition, 1903. London: The Homeland Association.



During spring and summer adolescents and delicate children should be greatly benefited by residence in this district.

There are several good hotels and comfortable lodging houses at Chagford, and excellent apartments may be obtained. (a)

Chagford is about 193 miles distant from Waterloo, and may be reached by a drive of about an hour and a half from Okehampton (L. and S.W.R.).

It can also be approached from Yeoford junction.

Perhaps the most convenient access is by Exeter, Newton Abbot, thence by rail to Moreton Hampstead (G.W.Ry.), and coach to Chagford.

Recently services of motor cars have been opened from Exeter (L.S.W.Ry.) and Moreton Hampstead (G.W.Ry.) to Chagford.

## Special Articles.

### THE CHEMISTRY OF FINE WINES.

BREWING has become a fine art in which the latest scientific discoveries are brought to bear, either to cheapen the cost of production or to ensure more perfect preservation. This applies with equal force to the "brewing" of wine, for we hardly know what other term to apply in respect of a beverage which undergoes so many and such complicated manipulations before being delivered to the public. We know that the Bordeaux wine merchants receive huge quantities of crude undrinkable wines from the South of France, Italy, Algeria, possibly even from California and Australia, and that from these unpromising juices they somehow prepare a wine which is characteristically "claret." The great difficulty with which they have to contend is that of controlling the fermentative process, in other words, of "fixing" the finished product. They overcome this difficulty by adding gypsum, which, in contact with the tartar (tartrate of potassium), becomes transformed into sulphate of potash, the lime being thrown down as a tartrate. The presence of an excessive proportion of the potash salt is injurious to health, and a limit has been fixed by law, in France, though in practice it is by no means uniformly enforced. White wines undergo another treatment, like alum in bread, for the purpose of making them appear whiter than they are. The agent employed is sulphurous acid, obtained by burning sulphur in the barrel before introducing the wine. Any excess of acid gives a certain pungency to the wine which, if not necessarily harmful to the flavour is reputed to be injurious to health. Some time since the Paris Council of Hygiene formulated a recommendation to the effect that wines containing more than twenty centigrammes of sulphurous acid, or two grammes of sulphate of potash, per litre must be regarded as unfit for consumption. Acting on this opinion the United States Government proposes to prohibit the importation of all wines falling within the scope of this resolution, and it so happens that certain high class wines of Barsac and Sauterne proved on analysis to contain nearly thirty-eight centigrammes of acid and close upon three grammes of the potash salt per litre. The news naturally excited considerable emotion in the French wine trade, and influence is being brought to bear on the home authorities to declare inapplicable the standard laid down by the Paris Council of Hygiene, and to make the necessary diplomatic protests to foreign governments.

The case for the wine manufacturers does not strike one as strong. In the first instance they advance the highly technical and elusive argument that the authority of the Paris Council does not extend to places outside the city walls, consequently, that its dictum carries no weight in Bordeaux. This argument is hardly *ad rem*, because, if the standard be a reasonable one, it must occur to everyone that if it is not generally applied it ought to be, and, moreover,

(a) See Ward and Baddeley's "South Devon"; also Dartington's "Exeter, Torquay, and Dartmoor."

on the face of it, the resolution errs if anything on the side of indulgence. Another argument, more plausible than the one just mentioned, is that it is absurd to apply to fine wines regulations which were intended to regulate only the sale of the ordinary qualities of wine in general use. They point out that while an excess of chemical substances in the latter may be prejudicial to health, in consequence of the much larger quantity consumed, it has practically no importance in the high-priced wines which, they assume, are always taken in strict moderation. There is obviously a certain amount of truth in the argument, though too much stress must not be laid on the assumption of moderation, and the stomachs of the well-to-do merit fully as much consideration as those of the poorer classes.

In view of the immense political influence at the disposal of the wine trade in France the question appears to be one which ought to be decided by the sanitary authorities of the wine-importing countries and not by the producers. So far as we are aware, there is no legislation bearing on this point, though in practice the presence of foreign substances injurious to health in wines would, no doubt, bring them within the scope of the laws prohibiting adulteration.

We do not pretend to settle the question of what is the proper limit in this respect, but we would suggest that if an excess be prohibited in Paris and in the United States, the propriety of enacting similar restrictions is likewise worthy of consideration at home. *Avis à qui de droit.*

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, October 1st, 1904.

### STOVAINE—A NEW LOCAL ANÆSTHETIC.

STOVAINE is a new local anæsthetic derived from tertiary amylic alcohol, discovered by Fournau. It crystallises in little brilliant flakes, much resembling cocaine; it is extremely soluble in water. The physiological properties of stovaine have been studied by Billon and Lannoy, while Dr. Ponchet read an important paper on it at the meeting of the Academie de Médecine, from which it appears that stovaine is much less toxic than cocaine; it is a vaso-dilator, it possesses an antithermic action, and has evident antiseptic properties. Its therapeutic applications have been studied by Prof. Reclus, Lapersonne, Chaput, Huchard, and by Mr. Sauvet, dentist.

According to Mr. Chaput, the analgesic action of stovaine is identical to that of cocaine. It is less toxic than cocaine, and has a vaso-dilator action which, producing congestion of the bulb, suppresses syncope and allows patients to be operated on seated, and to rise immediately after the operation. Injected into the lumbar region, it permits all kinds of laparotomies to be made with ease.

Prof. Reclus said that he injected more stovaine than he dared do cocaine, and he was able to perform operations under its influence which he could not have done with cocaine. It was thus that he was able on the same patient, and at one sitting, to remove four voluminous varicose veins, two from each leg, without the slightest pain to the patient.

The domain of stovaine, like that of cocaine, appears to him to be circumscribed tumours, cutaneous or subcutaneous lupus, lipoma, fibroma, cancroïdes, extirpation of the phalanges of the toes or fingers, ingrowing nails, whitlow, (artificial anus, umbilical hernia, hydrocele, varicocele, castrations, laparotomy for non-adherent ovarian cyst, empyema (with resection of the ribs). In his hospital practice, two-thirds of the operations were done with stovaine.

Mr. Lapersonne considered that stovaine was called

to render excellent services in ocular surgery. By instilling stovaine into the eye, all operations on the cornea and even that for cataract could be done. Injected into the conjunctiva, it was superior to cocaine; the insensibility was complete in less than a minute, and gave sufficient time for the operation.

Dr. Sauvet, dentist, said he had employed stovaine instead of cocaine for the last two months, and obtained excellent results. He employed a solution of 0.75 per cent. for the extraction of teeth, and never had an accident.

Prof. Huchard insisted on the total absence of the slightest toxic symptoms. He injected one-fifth, one-fourth and a half a grain for costal neuralgia, and none of the patients complained of headache, nausea or vertigo. At first he recommended the patients to keep lying half an hour, but afterwards he allowed them to rise immediately after the injection.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 2nd, 1904.

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

#### STREPTOCOCCUS CURATIVE SERUM

from clinical and experimental observations. The serums hitherto made use of had not been so successful as the diphtheria serums, as systematic clinical observations had been wanting. So much so had this been the case that prominent experts had declined to make use of them.

Two years ago he had commenced the attempt to immunise the larger animals, being guided in his experiments by two principles—(1) that the passage through animals had altered the streptococci, and (2) that the unity of streptococci had not been proved. He had, therefore, in his animal experiments used streptococci taken direct from the human subject only, and his preliminary treatment had been carried out by two forms alone, *viz.*, that found in suppuration and that met with in sepsis. In distinguishing the strains he had followed v. Behring's lead. These strains killed mice in doses of from 0.001 to 0.003 within twenty-four hours. He was of opinion that only a serum that is derived from strains that are pathogenic both for men and animals can be curative for the human subjects, and, therefore, can be made therapeutic use of. Animal passage, however, takes pathogenic property for the human subject along with it.

He had treated the following diseases in the human subject with his serum:—Simple angina, scarlatinal angina, erysipelas, articular rheumatism and sepsis. For a favourable result to be obtained only application of the serum was essential. According to his view, the serum destroyed the streptococci, and by this their toxins become free, so that with late use of the serum when the streptococci are present in large numbers, instead of a curative effect actual damage to the organism may follow.

Generally speaking, after one or two injections, a rapid fall of temperature and pulse takes place. This is frequently critical, sometimes not. Even in severe sepsis, a favourable turn often seems to take place. He would not recommend the use of the serum in mild cases, as such do all right with the usual means. But in cases that were evidently serious from an early stage he would recommend a trial with his serum, which at present was only prepared for experimental purposes in hospitals.

At a subsequent meeting, Hr. v. Openchowski gave a communication on

#### THE ACTION OF DIGITALIS IN REGARD TO SCLEROSIS OF THE RIGHT CORONARY ARTERIES.

Years ago he showed that digitalis acted on the left side of the heart only, and that the right heart was cut off from this action by narrowing of the right coronary arteries. This difference in action was of value as regarded the mechanism of the circulation. Many clinicians and pharmacologists had adopted his views. This dissociation was also of clinical importance. If the right heart acted more powerfully than the left, and set up dyspnoea, spitting of blood, oedema of the lungs, dilatation of the left ventricle, diminution in size of the right, a frequent small pulse (130), enlargement of the liver, and diminution in the quantity of urine, it was possible that more digitalis went to the right heart than to the left. This was rendered possible by dilatation of the right coronary arteries, through sclerosis and loss of power of contraction. The speaker had diagnosed three cases of sclerosis of the right coronary arteries, in which the left were only slightly attacked. In the last case the right coronary artery was doubled in size and completely sclerosed, whilst the left was narrow and elastic.

He then showed some cardiograms in which the right heart and jugular vein indicated heavy work, whilst the left curve was only slightly raised.

Herr Block showed a case of

#### BRACHYCARDIA.

A woman, æt. 48, of healthy parentage, and who on the whole had been healthy. Eighteen years ago she had ulcers on the vagina that were treated locally. Ten years ago the radical operation for cancer of the portio was performed, and at that time nothing abnormal was found about the heart. Four years ago, the patient was brought to the speaker for an opinion concerning violent attacks of pain in the stomach with diarrhoea. Examination showed symptoms of commencing tabes, but still there was no cardiac mischief. He had seen this patient off and on since that date. For three months she had suffered from peculiar attacks, which had become more frequent lately, up to ten or twelve in the day. The patient becomes suddenly giddy and unconscious and pale, the head is stretched backwards with, at the same time, a remarkable slowing of the pulse down to 36, 32, and 28. These attacks pass off in a short time. There is widening of the heart towards both sides, the beat at the apex heaving, the first sound dull, with a minimum capillary pulse. The symptoms of tabes had distinctly progressed. The cause of the brachycardia, considering the gastric crisis, was supposed to be an affection of the vagus, or it might be intra-cardiac. He had made an injection, but without result. The cause was therefore in the cardiac muscle, and all symptoms were dependent on a common cause, *viz.*, syphilis.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 2nd, 1904.

#### METEORISM AND LIVER CHANGES.

At the Naturforscher meeting Oppenheimer brought before the members the importance of liver changes in the diagnosis of disease, particularly peritonitis. From his experience in laparotomy sections, and also with animals, he is persuaded that liver dulness is an important factor in bonum, or in malum sensum, when temperature and pulse are not in harmony. The history of the case goes far to explain many morbid conditions when making differential diagnosis, but there often arise cases with

sudden deaths which we have difficulty in explaining. The same causes may be in operation that often occur in phthisical patients where enteroptosis or a falling of any of the internal organs, such as the liver, &c., may cause undue pressure and serious consequences. He related experiments on animals with the object in view of illustrating this accident by inflating the bowel and applying pressure to the chest, which rapidly produced cardiac stasis and sudden death.

Oppenheimer thinks that many of the accidents arising after the operation of anus preternaturalis are due to the high pressure in the bowel, which is not relieved after the operation.

#### INVAGINATION OF THE BOWEL.

Braun recorded sixteen cases of invagination of the bowel on which he had operated, eight of these being acute and seven chronic. In his opening remarks he said he could offer no explanation for the great number of these cases that occurred in other countries, especially in England, where acute invagination seems to be much more frequent than on the Continent.

The general opinion entertained by clinicians at the present time of the cause leading to this accident is spasm of a limited portion of the bowel and not, as was formerly believed, a paralysis of the bowel. Probably the diagnosis of this disease was not so accurately made as in other countries, which may account for the greater frequency to be found there. The symptoms generally met with in acute cases in children are sudden illness in a healthy child with tenesmus, vomiting, hæmorrhage, slimy mucus in the stools, with collapse and a distinct tumour at the site of the invagination to be found over the abdomen.

The chronic form is more difficult of diagnosis, which was demonstrated from preparations.

The treatment to be relied upon is operation as soon as the dislocation is observed. Removing it by manipulation or mechanical means, as reported in some hospitals, is not to be relied upon. Partial relief is no doubt frequent, but sooner or later the operation must be undertaken. Injecting air, water, and other fluids into the bowel have often been practised and may give temporary relief, but the bowel soon returns to its former malposition. It therefore remains to relieve by operation if possible what has not as yet been successfully done by resection. He considers the cause of this failure is due to the position of the buttocks after operation. Whatever may be the cause, he is in favour of an anus preternaturalis, which should be performed as early as possible in acute cases. It is often easy in these early opportunities to disinvaginate the bowel and relieve the sufferer without further delay or trouble. In the chronic form of invagination entero-anastomosis is considered the most successful operation.

It may be mentioned here that Eiselsberg has reported several successful cases by resection, but we conclude that they must have been in the very early stage.

In the discussion that followed, Kradel accentuated the difference of the frequency of this disease in England and Germany, for example. He had personally operated on eight cases of invagination without a single success. In three cases on which he did not operate, partial relief was obtained and the patient recovered. All of them were under one year, except one, and the youngest was eleven weeks old at the time of invagination. At the post-mortem the disinvagination was complete except in one case, which died of perforation and peritonitis. Whether operation is undertaken or not, the time necessary is exhausted. In

the case of reposition by injections of air or water, enormous pressure must be applied which cannot be long endured. If the operation be undertaken and disinvagination performed, it is difficult to prevent a return. Statistics seem to forbid heroic treatment. If the case be diagnosed early and operated on within a few hours there is hope for success; but if the intussusception has existed for any time the case is hopeless. Bartelsmann recommended injections and recorded four cases in which he was perfectly successful. The operation was not continued beyond an hour. Naunyn considered the diagnosis a very severe task in adults, but thought surgical operation the best. Braun concurred in this opinion of the diagnosis, which could easily be mistaken for any turning of the bowel or other enlargement.

Jächk related the history of two cases of disinvagination, which he accomplished with perfect success by injections. The ages were four and five months respectively, and the operations were undertaken nineteen and eleven and a half hours after the diagnosis was confirmed.

Pauli recorded the history of five cases which he had treated successfully.

Berge related a case which he operated on, and as soon as he had relieved the strangulated bowel the child died.

Wilmas discussed the production of invagination and described a few experiments he conducted on animals to prove that the cause was due to irritation of the longitudinal fibres of the canal, which causes it to fold in parts.

Kuhn reported 96 cases which he had observed. He thought the distribution of invagination of the bowel was very erratic. In Norway and Sweden this accident was very rare, while in Malmo and Copenhagen it was very common. Fifty to 60 per cent. of his cases were restored by manual treatment, such as massage and injections.

Braun and Madelung were surprised at these results, and instantly asked if 50 or 60 per cent. actually recovered without operative surgery, to which he replied in the affirmative. Was he sure he had diagnosed the cases aright as invagination? This he also affirmed was the case.

## Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, October 1st, 1904.

At the recent meeting of the Royal Hungarian Medical Society, Dr. Gaspar related his conclusions drawn from 125 cases of typhoid fever, in which the Widal test has been used.

1. The serum reaction may be obtained towards the end of the first week of typhoid fever, but is more usual later in the disease.

2. It may be present without a relapse at the end of the fourth month.

3. It may be absent one day and present the next.

4. Of 125 cases of typhoid fever the reaction was absent in only one case. In two cases it failed, but there was in each only one test, in one case on the twelfth, and in the other on the eighty-second day.

5. In nineteen cases of other diseases clearly uncomplicated by typhoid there was no reaction.

6. In a number of difficult and perplexing cases the serum test was of distinct service in establishing or correcting the diagnosis.

7. This test will probably prove itself a useful aid to clinical diagnosis, and especially in hospital practice.

Professor Herozel gave a *résumé* of the technique of pneumotomy. He avoids exploratory puncture, which he considers liable to infect the pleural cavity, and, in case the parietal and visceral pleura have not become adherent, liable to infect healthy lung tissue when the needle is withdrawn, and liable to cause severe hæmorrhage from puncture of large vessels. He does not practise it unless it is to be followed by pneumotomy, in which case the needle is used as a guide to the cavity to be opened.

The resection of the ribs should be free. He claims that the more extensively the lung is exposed, the easier does the examination in manipulation of the lung become, and the more rapidly will the cavity close and heal. One or two ribs are removed in the usual manner. Should three to four ribs be resected, a flap incision of the superjacent soft parts is the most satisfactory method.

After the resection, if the pleural surfaces are adherent, the operation becomes easier and safer. The retraction of the intercostal space on deep inspiration and the slight descent of the lower lung border noted before the operation, the speaker thinks, would indicate this. Sometimes after the resection of the ribs, the lung can be seen to slide up and down during respiration, as the intestine is seen through the unopened peritoneum. When adherent, the parietal pleura appears greyish-yellow, spotted with fat, thickened and dense to the touch. Finally, a fine needle pushed into the lung is adherent, and consequently fixed to the chest wall. A free lung would cause it to oscillate.

The attempts to produce this adhesion of the pleural surfaces by ignipuncture, electrolysis, cauterisation, chloride of zinc, and other methods have now been abandoned in favour of immediate union by suture. This, it is claimed, can be easily done by experienced operators, especially when the surface of the lung is exposed, and if it is forced into the wound by inspiration or coughing. The lung once fastened to the edges of the wound, its collapse or pneumothorax is avoided. The operation can now also be quickly finished.

As regards the pneumotomy in indurated, infiltrated, anæmic tissues, when the blood circulation is impeded, the lung can be satisfactorily opened with the scalpel, but since eventually the operator meets soft, healthy tissue, and is dealing with foul gangrenous tissue, in order to limit infection, the use of the Paquelin cautery is to be preferred.

The speaker considers that an anæsthetic is hardly necessary. He would not use ether. In an operation alluded to chloroform was used.

In regard to the results of operative treatment, Herozel claims to show that in ninety-one cases there was recovery in 60 or 61 per cent.

## The Operating Theatres.

### GUY'S HOSPITAL.

TWO CASES OF RENAL SURGERY.—Mr. CLEMENT LUCAS operated on a little boy, *æt.* 6, for pyo-nephrosis of the left kidney. The patient was passing a large quantity of pus in his urine, and had a temperature of 102°. The left kidney could be distinctly felt enlarged and fluctuating by bi-manual examination in the loin and the front of the abdomen. The trouble began by pain in passing water four years ago. At that time he was admitted into the hospital, and a stone removed from the bladder by supra-pubic lithotomy. The boy

was re-admitted two years later for a perinephritic abscess situated in the right loin. This was opened and drained, but its immediate cause was not at the time ascertained. The abscess healed after a time, and the patient was discharged in improved health. Since then, according to the mother, he has been wasting, and of late it had been noticed that his urine was very thick and had an unpleasant odour. Mr. Lucas diagnosed a distended pyo-nephrotic kidney on the left side, and cut down upon the left loin. After dividing the muscles and separating the perinephritic fat, an enlarged kidney came into view through which a number of pale cystic abscess pouches were visible. A small stone could be felt in the pelvis of the kidney. The pelvis was opened opposite this, and the stone removed with forceps. A quantity of exceedingly foetid pus then escaped, but the various abscess cavities failed to drain until Mr. Lucas, pushing his finger in various directions, opened their narrow orifices into the general nephritic pelvic cavity. The interior of the kidney and its various cavities were next washed out by repeated flushings with warm boric lotion until what returned was free from foetor. A large drainage-tube was fixed in the interior of the kidney so as to provide for continuous drainage till the organ had shrunk. Mr. Lucas said that in this case both kidneys appeared to have undergone suppuration as a result of ascending pyelitis consequent upon stone in the bladder. The right kidney discharged in all probability through the perinephritic abscess which occurred a year previously. The urgent condition for which the boy was admitted recently was due, Mr. Lucas considered, to the acute suppuration with distension going on in the left kidney, where a small phosphatic stone was discovered giving rise to obstruction, whilst acute bacterial infection was destroying the renal structure. The object of the operation, he pointed out, was to get free drainage of all abscess cavities within the organ by making them readily communicate with the distended pelvis. As the right kidney appeared to have recovered after discharging itself a year before, he hoped that by draining and disinfecting the left kidney and removing from it the obstructing stone, it might recover sufficiently to remain a useful organ. With a suppurating kidney, alkaline urine, and phosphatic stones, there was, he thought, always a question whether one may not be dealing with a tuberculous condition to which the stone is secondary.

As a result of the operation the boy's temperature immediately fell to normal and his general condition improved.

The second case was that of a man, *æt.* 27, who first came under Mr. Lucas' care a year previously. The patient had suffered from pain in the right lumbar region for fifteen years, but only on one occasion had had anything approaching a renal colic. For years he said there had been deposits in the urine, sometimes blood and pus in quantity. Röntgen rays failed to demonstrate a stone, and Mr. Lucas at that time said he was inclined to regard the case as one of tuberculous kidney. He explored the kidney through the loin and found large branching phosphatic calculi surrounded by pouches of pus of a very foetid character. The calculi were removed, the cavities washed out, and the kidney drained for a time, after which the wound was allowed to heal, and the patient left the hospital greatly relieved. In the spring of the present year, he began to be reminded again of his kidney by a recurrence of pain in

the right loin. Soon after, the deposit of pus, which, though greatly diminished, had never entirely disappeared, began to increase in quantity. The patient was re-admitted a week before the present operation, when the kidney could be distinctly felt to be considerably enlarged, and Mr. Lucas concluded that suppuration was still going on within it. As the man never had any pain in the other kidney, and as he passed a fairly good amount of urea by the normal passage at the time the kidney was drained a year before, and considering the extensive damage to renal structure discovered at the first operation, Mr. Lucas advised the patient to submit to excision of the kidney if at the time of the second operation the organ was found to be practically useless. At the operation an incision was made just above the level of the old scar in a transverse direction, and this was enlarged by a vertical incision corresponding to the anterior border of the quadratus lumborum. The capsule of the kidney was found to be closely adherent to the perinephritic fat and other structures, so that it would have been impossible to remove the kidney with its capsule. Mr. Lucas, therefore, first emptied the organ by puncturing it with a large cannula, then tore open the capsule, and stripped the kidney out from within the capsule till he reached the point where the fleshy substance became continuous with the pelvis and the main vessels. At this point the pedicle of the kidney was transfixed and ligatured, the substance of the organ being all cut away. Very little hæmorrhage took place during the operation. A large packing of cyanide gauze was used for drainage. Mr. Lucas said that the pathological examination of the kidney showed that the organ was tuberculous, although repeated examinations of the urine had failed to find any bacillus. The fact that the tubercle bacillus was at work in the kidney accounted, he thought, for the disease not clearing up after the complete extraction of the phosphatic stones fifteen months before. Thus the second operation, which comprised the removal of the kidney, brought the diagnosis back to that originally made before the extraction of the phosphatic stones, and it would seem that the formation of these stones was probably secondary to the tuberculous process causing alkalinity of the urine and precipitation of the phosphatic salts therefrom.

Since the operation the patient has progressed favourably and his temperature has remained normal.

#### Case of Bubonic Plague in the Tyne.

BUBONIC plague was last week reported to have broken out on board the London steamer, "Bishopsgate," which arrived in the Tyne from Hamburg, and was placed under strict observation. While the vessel was at Hamburg, discharging a cargo from Rosario, rats which had died from plague were found on board. At Jarrow it was necessary to remove to the floating hospital for infectious diseases the boatswain, a German, who only joined the vessel at Hamburg before she left for the Tyne, and a bacteriological examination made by Dr. Harker showed that the patient was suffering from bubonic plague. The "Bishopsgate" has been carefully disinfected and allowed to leave the Tyne, the remainder of the crew being found all well.

#### Harveian Society of London.

THE opening meeting of the seventy-fourth session of the Harveian Society of London will be held at 8.30 p.m., on Thursday, October 13th, at the Stafford Rooms, Titchborne Street, Edgware Road. Mr. C. B. Keetley will deliver the Harveian Lecture for the year, the subject being "Plastic Surgery."

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## The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 5, 1904.

### MR. CORONER TROUTBECK ON YOUNG SURGEONS.

THE position taken up by the London Coroner, Mr. Troutbeck, with regard to medical practitioners and their evidence generally may be characterised as unfortunate. Sooner or later it seems more than probable that his ill-advised tactics will lead to disastrous consequences, so far as the relations of the Coroner's Court, the public, and the medical profession are concerned. The leading principle which has guided Mr. Troutbeck, and upon which he has dilated in season or out of season, is the incompetency of the general practitioner. If any person dies of cerebral hæmorrhage, or of advanced heart disease, or from any other ordinary morbid condition, the medical practitioner who is certified as competent to attend to the health of our fellow-citizens during life is nevertheless incompetent, according to this sapient Coroner, to ascertain and certify the cause of their deaths. To tell us how they die demands the services of an expert "pathologist" (save the mark!), whose expertness is apparently to be decided by a standard fixed by Mr. Troutbeck. The gentleman singled out by the Coroner for that distinction deserves nothing but sympathy. He has been placed in a false position, whilst his services are utilised to deprive certain of his professional brethren of a considerable amount of legitimate medical practice. It was originally announced that Mr. Troutbeck's "expert" was to be called in at a special fee in difficult and obscure cases only. With that arrangement there would not have been much room for difference, as it is obvious the Coroner should have some latitude in his power of summoning highly-skilled aid under special circumstances. As a matter of fact, the simplest and most ordinary cases are placed daily in Dr. Freyberger's hands by Mr. Troutbeck. We have no hesitation

in asserting that in a large proportion of these cases equally good or better evidence could be furnished by local medical men, who in many instances have attended the deceased during life. There is little need, however, to discuss either the facts or the merits of the dispute that has arisen between Mr. Troutbeck and the medical profession. The whole matter has been investigated by a sub-committee of the British Medical Association, which has collected, sifted and arranged facts, evidence and conclusions with masterly precision. A correspondence with Mr. Troutbeck has simply evoked contemptuous defiance and evasion of issues, together with a flat denial of what appear to be incontrovertible statements. Nor has a further appeal of the committee to the Lord Chancellor, under whose jurisdiction the Coroners fall, produced any more satisfactory result. The next steps of the British Medical Association committee will be awaited with interest. If Mr. Troutbeck is unwise enough to declare war to the knife with the medical profession, he will most certainly raise issues of a far wider significance than those that appear on the surface. The machinery of the Coroner's Court is antiquated, and its procedure often slipshod and unsatisfactory to a degree. It is a question whether the whole system could not advantageously be replaced by a simpler court of official inquiry framed somewhat on the lines of those of the Procurator Fiscalship of Scotland. Meanwhile, nothing but harm can result from the unceasing flouts and jeers which Mr. Troutbeck sees fit to fling at the heads of all medical men except that of his pathologist, who is now openly announced as pathologist to the London County Council. The inner history of that appointment has not yet come to light, but it seems not unlikely that the policy of distrust of the general practitioner may one day be traced to one or more influential members of that body. If the Association committee want to get at the root of the matter, we should advise them to ascertain the attitude of medical members of the London County Council with regard to Coroners and to the appointment of Dr. Freyberger. The latest feat of Mr. Troutbeck has been to launch a particularly offensive attack against house surgeons generally. One of his jurymen not unnaturally asked why the evidence of a house surgeon had not been taken, whereupon the Coroner explained that the testimony of such persons was of little value. The dispute between the profession and Mr. Troutbeck has now been going on for a long time. Remonstrances and arguments have been of no avail, as that gentleman now clearly shows by fastening a gratuitous insult upon the large class of resident medical officers, many of whom are highly qualified and brilliant men. The time is come for legislative interference in the relations of the Coroner's Court and the medical profession. The situation has grown intolerable. In the long run it may be that the thanks of medical men, as well as of the general public, will be due to Mr. Coroner Troutbeck for the persistent way in which

he has forced the flaws and the potential powers of maladministration of the Coroners Acts upon the public attention.

#### CHRONIC CASES IN HOSPITAL WARDS.

THE question of the suitability of individual cases for admission as in-patients to hospitals requires the exercise of a good deal of judgment about the exercise of which evidently exists some misconception in the minds of those who are responsible. The two chief factors which influence the decision are, first, the urgency of the case; and, secondly, the in-patient capacity of the hospital. Every resident medical officer knows, or should know, that he is perfectly justified in temporarily exceeding the bed-accommodation at his disposal in times of emergency. Overcrowding of hospital wards is, of course, an evil to be rightly avoided, but few medical superintendents will be found who would seriously object to go beyond the theoretical limit if, for example, a bad accident or a case demanding speedy operation required admission. Preference must always be given to acute cases, and the smaller the hospital the more necessary it is that this rule should be enforced. We have known of instances where serious accidents have been sent away from hospitals on the ground that there was no accommodation, whereas, if the truth were known, the beds were largely taken up by chronic cases, awaiting their discharge or the application of a long-delayed plaster splint. Mere slackness on the part of house-officers is neither the only nor the chief cause of the filling of beds by unsuitable cases. In some districts the subscriber's letter system has such power that a patient, armed with this document and suffering, it may be, from some trivial complaint, which could quite well be treated in the out-door department, is instantly admitted into one of the few vacant beds of which he or she takes triumphant possession, while the unfortunate individual, stricken by mortal sickness, but unprovided with such a passport, is wholly unable to find shelter. This is by no means an imaginary occurrence. In other cases, patients are admitted with lingering diseases, such as chronic phthisis, or incurable nervous affections, who would be better off in their own homes or in the Poor-law infirmaries, for it is obviously unfair to keep a single bed occupied for months in succession by a patient for whom little good can be done, when in the same space of time five or six acutely suffering ones might have been permanently cured by operation or otherwise. The whole question is of immense practical importance, both to the general public and also to the governing bodies of the hospitals themselves. Where there is a medical school attached to a hospital the "chronic case," considered in the abstract, has a definite part to play in clinical instruction, for it often happens that bedside teaching is impossible upon acute cases, either from the severity of the symptoms or because the patient is frequently admitted at night. Chronic cases, on account of the stationary or



slowly changing character of their physical signs, are particularly suitable for clinical examination by students, and a good teacher can always find some fresh point upon which to dilate when the regular ward visit takes place. But in hospitals without a medical school, where the number of beds is more or less limited, an intelligent selection of cases for in-patient treatment must be made, due consideration being paid both to the relative severity of the symptoms and also to the claims of the outside supporters of the institution. All suffering, chronic or acute, must be relieved, and how this can best be done with the greatest possible benefit to all is one of the problems which we are glad to think is, on the whole, being daily solved in our hospitals and infirmaries.

### Notes on Current Topics.

#### Dearth of Medical Men in Russia.

THE evils of a great war reach far beyond the battlefields on which the trial of strength is made. The penalties of suffering and death may be paid by innocent sufferers many thousands of miles away from the scene of action. Too often the bread-winners—fathers, sons, husbands and brothers—are called to fight the battles of their country, which does not always provide adequately for friends and relatives in case of death or disablement. Another way in which those left at home may indirectly suffer is in the dearth of medical men, of whom the flower is called away to every campaign. In the South African War even our own overcrowded medical profession was depleted to such an extent that the pinch was everywhere felt in the lack of stop gaps and of resident assistants and medical officers. At the present moment in Russia, where a war is being waged on a scale far surpassing our own South African campaign, the want of medical men in country districts is making itself most keenly felt. Thus a London newspaper reports that there is no one to fill up the gaps caused by medical men who have gone to the war. The usual possible candidates have themselves gone to Manchuria with the many field-hospitals that have been equipped by the Red Cross Society, the town councils, and other public bodies, and, in many instances, by private enterprise. The wicked waste and wantonness of war was never more cruelly shown than in these districts of rural Russia drained of their medical men. Under any circumstances it seems that the inhabitants of that country are destined for years to come to pay a toll of daily sacrifice for its attempts at foreign annexation.

#### Bacteriology of Pertussis.

CONSIDERING the easy field for study offered by whooping-cough it is a matter of some surprise that we are still without any decided knowledge as to the causative organism. It is a common disease in most countries, so that there is no lack of clinical material on which to work. Moreover, for generations it has been recognised as infectious, and no observation has thrown any doubt on this belief.

It has been established that the sputum may act as a vehicle of infection, although not perhaps the only one. In addition to these facts, all tending to bring the disease into the region of easy investigation, it is known that one attack confers immunity, a second attack in the same subject being extremely rare. In spite of all this, there is as yet no general agreement as to the nature and history of the organism at work. It is true the investigations have not been wanting, but the results, where there are any, are greatly at variance with each other. One of the most elaborate inquiries was that conducted some years ago by Czaplewski, who found in every case of a series of forty-nine a small bacillus resembling that described in connection with influenza. This bacillus he regarded as the cause of pertussis, although he was unable to obtain any experimental proof. More recently Manicatide has described a very similar bacillus which he found in sixty-seven out of eighty-two cases examined. It differs, however, from Czaplewski's bacillus in certain staining and cultural reactions. It, however, gives the agglutination reaction with serum from patients affected with whooping-cough, and an antiserum produced by inoculating sheep and horses is stated to have been of service in the treatment of the disease. It is possible that further inquiry may establish the identity of Czaplewski's and Manicatide's organisms, but at present the whole question is in a very unsettled condition.

#### Suprarenin in Surgical Operations.

THE great therapeutical use that was anticipated from animal extracts when they were introduced into practice some years ago has hardly been justified in the majority of instances, but in the case of supra-renal gland extract a powerful and valuable drug has been placed at our disposal. In fact, its full uses are probably not thoroughly grasped yet. A series of experiments by Müller (a) seems to show that, in surgery, it may lend invaluable aid in the performance of quite extensive operations by allowing them to be performed practically without loss of blood. Müller found that by previously injecting the parts to be cut with suprarenin solution, not only was the operation rendered far easier of performance for the surgeon, but also the amount of shock was diminished by averting the loss of blood. He experimented on animals, removing portions of the liver and the kidney, and performing excision of glands, rib-resection, and laryngectomy. No blood was lost if a sufficiently strong injection was given, and no toxic symptoms were noted. Suprarenin hydrochloride in salt solution was used in strengths varying from 1-1,000 to 1-10,000, and was freely injected into the site of the projected operation. Its vaso-constrictor effect was well marked in half a minute in the case of strong solutions, and in one or two minutes when the weaker ones were employed, Müller thinking that in man the most that it is advisable to give is 10

(a) *Muench. med. Woch.*, Nos. 5 and 6, 1904.

cubic centimetres of a 1 per cent. solution, but as this is sufficient to render all operations bloodless, no more could ever be wanted. We wonder if the surgery of the future is to be as free from blood as it is now free from pain, and if suprarenin is to be the agent. If so, the act will have lost its greatest present drawback, and no greater boon since the introduction of antiseptics will have been conferred on both operators and their patients.

#### Speech, Silence, and Bacteria.

THE world has been recently set agape by the published investigations of the Local Government Board into the subject of the sputtering forth of bacteria in the act of speaking. It was shown that in ordinary quiet speech bacteria were emitted only rarely. In all abnormal respiratory acts, however, such as speaking loudly, laughing, coughing, sneezing, and so on, these micro-organisms, with all their powers for good or for evil, were distributed right and left in wholesale fashion. In some instances, indeed, we are told they were traced to a distance of forty feet. It is just as well to remind our readers that the whole subject was dealt with some time ago by Dr. Mendès de Léon, of Amsterdam, who showed experimentally that many micro-organisms were expelled from the mouth in particles of saliva expelled by the act of speaking. He drew the attention of the British Gynaecological Society to the danger of the contamination of open abdominal wounds in this way by the operator speaking to bystanders. The practical outcome of his work was a mask devised to prevent the particular risk in question. The article was published at the time in *THE MEDICAL PRESS AND CIRCULAR* (January 27th, 1904). An editorial comment on Dr. De Léon's researches appeared at the time under the heading of "Silent Surgeons." Our remarks had a wide circulation at the time among the lay newspapers. It is to be hoped they will give equal publicity to the fact that the honour of the original discovery is due to a distinguished surgeon of Amsterdam.

#### Pepper as a Dressing for Wounds.

IT is never wise to dismiss popular notions as nonsense without careful critical examination. There is no smoke without fire, and it often happens that man finds out the right thing by rule of thumb generations, or it may be centuries, before the light of exact science is available. Take the instance of pepper as a dressing for wounds in the rough and ready veterinary surgery of the farm and the stable and streets. The carman who borrows a pepper-pot from the nearest public-house and liberally bestrews with pepper the cut on his horse's knee wots nothing and cares less that the essential oil of pepper is a strong aromatic and stimulant antiseptic. He knows, however, that the wound will heal quickly under that treatment, and that is enough for him. There is not the least ground for supposing that pepper is a painful dressing for a wound, indeed, anyone who cares to try it on a cut finger will find it infinitely less

painful than a score of other things used for the same purpose. But, forsooth, because it is a strong stimulant to the tongue certain wiseacres are apt to imagine that it must be equally powerful when applied to cut tissues, forgetting, or not knowing, the differing response to stimulation of nerves of special and of ordinary sense. Acting on this nonsensical view, some magistrates actually sent to prison for several weeks an unfortunate man who peppered a horse's wounds. The so-called cruelty was a rough kind of antiseptic surgery. The sentence in question was barbarous, inane, ridiculous, and absolutely unworthy of the spirit of the present scientific age, which clearly has not yet permeated the magisterial bench of the kingdom.

#### Toxins and the Eye.

AS might be expected, the conjunctival surface, like the rest of the surface of the body, has a rich bacterial flora. Among the commoner bacteria present are the staphylococcus aureus and the micrococcus lanceolatus. While these or other bacteria are present in small numbers, or on the surface of the eye, no inflammation results, so that it is evident that they do not cause inflammation simply by acting as foreign bodies. Inflammation can be caused by certain bacteria alone, and that only after a certain period of exposure to them has taken place. It is probable, then, that the action of bacteria on the eye is due to the production by them of certain toxins, and this occurs only when the organisms are in, and not merely on, the conjunctiva. Experiments with the toxins of the bacteria which are known to affect the eye bear out this conclusion. Randolph of Johns Hopkins Hospital, who has devoted much time to the subject, was unable to produce any injury by the mere instillation of bacterial toxins into the conjunctival sac, even with several hours' contact. On the other hand, the same toxins when injected into the tissues of the eye produced marked changes, varying in kind and degree with the bacterial source of the toxin employed. An interesting practical point is that the presence of even virulent bacteria on the conjunctiva is probably harmless, so long as the covering membrane remains intact.

#### Alcoholism and Insanity.

THERE is no class of disease of whose causation we are more ignorant, and in which the public take more interest, than those of the mind. And, indeed, there is no more difficult task than for an alienist to pick out from an imperfectly-known and often deliberately misleading personal history, taken in conjunction with a still less known original constitution, some one factor or habit and label it alone as the cause. It is the entire group of antecedent conditions which is in truth the cause of anything, as Mill long ago insisted, and in the case of disease, and especially of disease of the mind, is this particularly to be remembered. In the selection of one of these conditions and the setting it up as the cause, there is, when the group of conditions is large, ill-defined, and imperfectly

known, a great latitude given for individual bias. In the classification of the causes of insanity, for instance, no two observers would be likely to return the same table for any hundred patients. This being so, we are not surprised that Dr. Clouston's opinions recently put forward as to the prominence of alcoholism as a cause of insanity have not received quite the respect which is due to any observation by that distinguished alienist. His judgment that in 42·3 per cent. of the male patients in the Royal Edinburgh Asylum last year drink was the cause of their condition is in marked contrast to the figures of other observers. Thus the average throughout the English asylums is returned as 16 per cent., though on the other hand Dr. Conolly Norman, of the Richmond Asylum in Dublin, approaches Dr. Clouston's views. It is very noticeable and strongly in support of their opinion that in the special form of insanity known as "alcoholic," about whose diagnosis there is no mistake, there has been a decided increase in recent years. At the same time it is not necessary to assume that drinking habits are actually on the increase. It would explain the facts, if in truth they are facts, equally well to hold that there is a diminished resistance on the part of the organism to alcoholic poisoning. We are inclined, indeed, to think that in many cases the alcoholism is primarily a symptom of the mental weakness which it in turn increases.

#### Australian Surgery Thirty Years Ago.

THE present generation of medical men find it next to impossible to draw a picture of the conditions which obtained in surgical work in the early seventies. We have grown up so completely in the age of anæsthesia and asepsis that we find it hard to realise that there was a time when these were not, and we are always interested to hear the pre-revolution reminiscences of our seniors. Dr. Melville Jay, of Adelaide, gives us in a recent address (a) an interesting sketch of what surgical work was like in the Southern Hemisphere when he began his professional life more than thirty years ago. Though anæsthesia was, of course, at that time the common practice, yet it was regarded as by no means a necessary adjunct to operations. Dr. Jay saw one unfortunate patient who, within a few days, suffered amputation of a leg and enucleation of an eye without any attempt to numb his sensibility. In the early seventies chloroform was the favourite anæsthetic used in Australia, but in 1875, following on the occurrence of some deaths under chloroform, an exhaustive inquiry was made by Dr. Thomas on the relative advantages of ether and chloroform. As a result it was made obligatory by the governing body of the Adelaide Hospital that ether should be the anæsthetic used when possible. After thirty years' experience, Dr. Jay finds the decision amply justified, and he has never seen a serious result attributable to ether anæsthesia. In the operating theatre it was unusual for the surgeon to wash his hands before operating, though he usually did so

(a) *Australasian Med. Gazette*, July 20th, 1904.

afterwards. It was the custom for him to wear a frock coat throughout, and the more numerous the blood-stains thereon, the prouder he was. Ligatures were always left long and hanging from the wound, and great pains were taken in learning the exact amount of force which should be employed in removing them later without bringing on secondary hæmorrhage. It was the duty of the house surgeon each day to pull on the ligatures until one by one they came away. In the treatment of dislocations use was made of a complicated and powerful system of pulleys, and in 1873 the thumb of a young man was all but torn from his hand by this apparatus. It is hardly matter for wonder that cases of pyæmia, septicæmia, erysipelas, and hospital gangrene were common in the surgical wards.

#### The Effect of Smoking Upon the Throat.

ONE of the evils resulting from the excessive or, in some cases, even the moderate use of tobacco is its peculiar effect upon the pharyngeal mucous membrane. The exact nature of the pathological processes which may follow too great indulgence in smoking is not always easy to determine since these are by no means constant. Then different laryngologists or throat specialists would, in all probability, give as many different theories as to the manner in which the fragrant weed may prove injurious to the pharynx and upper air passages. Definite teaching upon this point is most desirable, for the subject appeals with force to singers, speakers, and many others whose vocal organs are being constantly exercised. The so-called "clergyman's sore throat" is always supposed to be aggravated by smoking, but no one will assert that this is a common or a chief cause of chronic pharyngitis, which occurs in those of nervous temperament too frequently to be merely accidental. A recent analysis of tobacco smoke from cigarettes shows that there are 410 c.c. of carbon monoxide per 100 grammes, and it is the opinion of experts that it is this gas and not nicotine which does the greatest amount of harm. This was the view taken by Dr. S. W. Langmaid, of Boston, at a discussion upon the subject before the annual meeting of the American Laryngological Society, who stated that the quantity of nicotine carried to the throat was really very small as compared with the amount of carbon monoxide which was absorbed into the system and then produces vaso-motor disturbances in the pharynx. Singers with voices of low register appear to be less affected by smoking than those whose voice is of a higher pitch.

#### Temperance Lectures in Schools.

THE sympathetic hearing given by Lord Londonderry the other day to the deputation of the medical profession that waited on him to urge the importance of teaching hygienic and cognate subjects in elementary schools has not yet borne practical fruit. One of the points most strongly insisted on by the speakers of the deputation was the good likely to accrue to the rising generation by clearly setting before them at an early stage of their career

the moral and physical dangers of alcohol. It seems that in the Cheshire schools such instruction has been given for some years, and the County Education Committee when it was formed passed a resolution that these lectures should be continued. Unfortunately, teaching in such subjects is not included in the school curriculum mapped out by the seers of Whitehall, and the Government Inspector has been obliged to point out to the Committee that the Board of Education have consistently refused to recognise lectures on alcohol and temperance as fit subjects for inclusion in the school time-table. Dr. Hodgson, however, seems to have been equal to the occasion, for he proposed that the lectures should be given as object-lessons in elementary science, and moved the Committee to take on their own shoulders the responsibility of the lectures, so that the local managers might not be exposed to continual wrangles with the inspectors. The County Committee adopted the motion by a large majority, and as they are the authority for secular education the matter seems to be well within their province. Undoubtedly the study of inebriety and alcoholism is a "science," though, perhaps, one that is hardly contemplated by the syllabus of the Education Board, and as such may be taught; but we wonder where the object-lessons are to come from. Will the local public-houses be laid under contribution? Or will the teacher merely simulate the symptoms of intoxication? We hope, at all events, the Cheshire Committee will win their fight, and these useful lectures be continued.

#### City Orthopædic Hospital.

THE position that the City Orthopædic Hospital finds itself placed in is an embarrassing and anomalous one. The Metropolitan Hospital Sunday Fund have refused it their annual grant because the Governors of the institution continue to oppose the amalgamation of their hospital with others that call for a similar class of case; there has been no reflection on the management or treatment of patients; the question is purely one of policy. On the other hand, a good deal of sympathy, implied and expressed, has been shown by people who have taken interest in the hospital in the past, and by new friends whom they have won over to the cause. A scheme for placing the City Orthopædic on a footing that will render it independent of the Hospital Sunday Fund is now on foot, and there seems some prospect of success being attained. Without expressing an opinion on the merits of this particular question, one may point to this incident as an example of the necessity of some central body, such as the King Edward VII. Hospital Fund for London, definitely taking on its shoulders the onerous, invidious, but necessary task of deciding by public inquiry all questions of hospital policy and administration. As we have before pointed out, the King's Fund is in an immensely strong financial position with its income of £100,000, and it can command the services of the best talent, lay and medical, for work of this kind. It is neither fair to individual hospitals nor to the

public that these questions should be made foot-balls of in the columns of the daily Press. They are capable of definite solution if taken in hand by an authoritative body, and the committee of the King's Fund is obviously the right body for the purpose. Only all its proceedings should be carried out in the full light of publicity. We propose to allude in an early issue to the action of the Fund with regard to the sale of the site of the Royal Orthopædic Hospital under the chairmanship of Mr. Harry H. Marks, and its amalgamation with the National Orthopædic Hospital.

#### Radium Rays in Diphtheria.

It is, of course, only right that any substance that shows promise of being of service in the treatment of disease should be fully investigated therapeutically, but it must be confessed that experience gained in the applicability and utility of radium has not fulfilled all the hopes that were entertained when the metal was first discovered. There may still be disease conditions in which radium rays will prove themselves superior to those of Röntgen and Finsen, but it would seem from some careful researches carried out by Professor Prescott at the Massachusetts Institute of Technology that radium has little, if any, germicidal power. Experiments were made on the destructive effects of radium rays on micro-organisms in such widely differing resistances as *Bacillus coli*, *Bacillus diphtheriæ*, and *Saccharomyces cerevisiæ*, all of which were exposed for varying periods up to ninety minutes. None of these bacteria seemed to be much affected by the emanations, and Professor Prescott thinks that on whatever grounds radium rays may be useful in disease, it is not on that of the bactericidal properties. Other observers have claimed that two days' exposure will kill *Bacillus typhosus* and anthrax spores, but such a lengthened period of application is hardly possible in the treatment of patients, especially as the rays have shown that they can set up inflammatory or destructive changes in the tissues. Professor Prescott asserts that radium is certainly not adapted to the treatment of diphtheria, and that it should not be allowed to take the place of anti-toxin. The fringe of the possibilities of radium is yet only reached, but one is glad of definite evidence, even when negative, as to its ascertained potentialities and limitations.

#### The Journal "Public Opinion" and the Hospitals.

THE rejuvenation of an old-standing London journal—*Public Opinion*, to wit—has resulted in a number of the more or less familiar advertisement schemes that characterise modern journalism. As a medical journal we are concerned only with one of them—namely, a plan to benefit the hospital by prize competitions. Prizes to the extent of several thousand pounds, divided into sums varying from £200 downwards, are offered to those who collect and send in the largest sums to the office of the weekly journal above mentioned. There is not the slightest attempt to disguise or conceal

the fact that 25 per cent. of the money thus contributed will be appropriated for prizes and the necessary outlay. As pointed out by the editor of *Truth*, who has taken the matter vigorously in hand, the commercial nature of this journalistic venture is self-evident. The nature of the scheme, at any rate, is openly declared; and there can be little doubt that many medical charities spend at least 25 per cent. of income in the machinery of collection. It would be interesting to learn what is the precise proportion of income spent upon collection and upon administration by the London Hospital Saturday and Sunday Funds and, above all, by the Charity Organisation Society. We cannot, however, approve of the enterprise of *Public Opinion* in the present instance. Unfortunately, there are many axes in the hands of servants, tradesmen, landlords, and philanthropists that are daily ground at the expense of our medical charities.

#### The Supply of Drugs to Irish Unions.

THE question of the supply of drugs to Irish Unions is again assuming importance. It will be remembered that some years ago rather startling facts were elicited as to the methods in vogue for obtaining contracts. The method of tendering suggested by Dr. Stafford, a member of the Local Government Board, was then adopted, with eminently satisfactory results for a time. It now transpires, however, that many of the leading firms of wholesale chemists in Ireland have ceased to tender because it is impossible for them to compete with the prices quoted by others. In many cases, rebates are offered on the official price list as much as 37 and 40 per cent., with the result that many articles are supplied below their cost price. It is suggested that the Local Government Board intend to hold an inquiry into the causes which have caused leading Irish firms to cease tendering; but inasmuch as it is admitted that the Unions are receiving good drugs at a lower price than they ever did before, we doubt that the Board will consider itself called upon to interfere.

#### Bedding and Disease.

THE fitness of the bedding upon which we lie and with which we cover ourselves at night has an important bearing, not only upon the character of the sleep but also upon the general health, and it is accordingly not less worthy of attention than other matters concerned in the hygiene of the bed-chamber. The cause of the unrefreshed feeling which many people experience on rising in the morning is not always due to deficient ventilation. The necessity for pure air in the sleeping apartment is gradually becoming more recognised by the public, but the voice of the health lecturer has not hitherto been specially uplifted with regard to the quality and quantity of the bedding itself. To heap up blankets, coverlets, and rugs does not confer, in reality, any greater warmth than two or three light coverings of suitable texture, as, for instance, a sheet, blanket and eider-down quilt, while it is frequently productive

of the heavy, unrefreshing sleep of which so many complain. The old-fashioned, but extremely unhealthy habit of sleeping in the same garment next the skin which has been worn during the day is still rife among those who have, or think they have, a tendency to rheumatism, and any suggestion as to discontinuing this unpleasant custom is apt to be resented. The same curious conservatism is shown with regard to the feather-bed, which is a crafty device contrived to absorb a maximum of the organic matter thrown off by sleeping. Lying upon hard beds has cured many complaints of a congestive character, and the modern spring-mattress is capable of being purified with greater ease and at less expense than its older rival. The wool flock contained within the mattress is undoubtedly a possible source of danger to health, as has been recently pointed out by a sanitary inspector in Glasgow, who stated that analyses of this material in many cases compared unfavourably with ordinary sewage! Efficient sterilisation by heat should, however, suffice to render the wool flock perfectly innocuous as a material for bedding which, on account of its cheapness, is almost universally used.

#### Progeries and Senilism.

It is not long since our knowledge respecting the conditions which lead to that variety of physical immaturity known as infantilism was considerably enriched by the able and lucid description of a series of cases by Mr. Hastings Gifford. The same observer, in a valuable communication to the *Practitioner*, has described a peculiar condition of retarded development combined with premature old age, to which he gives the very appropriate name of "progeries" (*Gr progeros*), prematurely old). Three cases are narrated which died at the ages of seventeen, eighteen, and forty-three, respectively. The patients were all like children in stature, but of a peculiar wizened appearance, and possessed a wrinkled, atrophic skin. In intellectual power they were somewhat precocious, but otherwise the physical functions were normally performed. Mr. Gifford defines the condition as one of "infantilism upon which has descended the blight of premature old age," and in this connection it is interesting to observe that at the post-mortem upon the first case atheromatous changes were found with commencing calcareous degeneration in the coronary arteries and upon the valves of the left side of the heart. Premature senility alone is of frequent occurrence, but when it is found in conjunction with infantilism the result is pathologically most incongruous.

LIEUTENANT-COLONEL E. M. WILSON, C.B., C.M.S., D.S.O., recently retired, since his appointment as surgeon in 1881 has seen active service in the following campaigns: Soudan, 1884-85 (medal with clasp and Khedive's bronze star); Soudan Frontier Field Force, 1885-86; expedition up the Gambia, 1891-92; Ashanti expedition, 1895-96; Nile expedition, 1898 (mentioned in despatches; appointed D.S.O. and medals). Before this

record he served in 1879 as civil surgeon in the Zulu War (medal and clasp).

#### PERSONAL.

HIS MAJESTY THE KING has graciously approved the appointment of Lieutenant-Colonel Richard Philip Smart, Chief Government Medical Officer and Superintendent of Public Health of the Island of Malta, to be a member of the Executive Council and an official member of the Council of the Government of that island.

THEIR Royal Highnesses Prince and Princess Henry of Prussia have shown their sympathy with the work of the London Royal Waterloo Hospital for Children and Women by a letter of sympathy and an annual subscription of five guineas.

FLEET-SURGEON J. C. DOW, M.B., has retired from active service with the honorary rank of Deputy-Inspector-General.

DR. J. B. HOGG, Inspector of Asylums in Queensland, in his annual report recently presented to the Houses of Parliament, points out that the proportion of insane to the general population is steadily increasing in all the Australian States, and in a ratio greater than that of the United Kingdom.

THE Harveian Lecture will be delivered on Thursday evening, October 13th, by Mr. C. B. Keetley, on "Plastic Surgery."

MR. C. M. TUKE will deliver the Presidential Address of the 23rd Session of the West London Medico-Chirurgical Society on Friday evening, October 7th, upon the subject "Progress in Psychology."

SIR JAMES RECKITT, of Hull, has generously offered to double the amount of the Hospital Sunday Fund collected in that town, after the first thousand pounds have been reached.

DR. E. SYMES THOMPSON will deliver a course of four lectures on "Evolution in the Vegetable Kingdom" on October 4th and the three following days, at Gresham College, London, at 6 p.m. each day.

ON October 20th, Lord and Lady Rothschild will open the administrative buildings of the Epileptic Colony at Chalfont of the National Society for the Employment of Epileptics.

DR. CHAMBERS will entertain members of the South-Eastern Division of the Medico-Psychological Association at luncheon, at the Priory, Roehampton, London, S.W., on Thursday, October 6th.

DR. R. MURRAY LESLIE is the new President of the North-East London Clinical Society, of which the present winter session will be inaugurated by an address on October 6th by Sir R. Douglas Powell on "Antiseptic Principles in Medicine."

LIEUT.-COLONEL P. M. ELLIS, now commanding the 9th Company of the Royal Army Medical Corps at Colchester, has been appointed Principal Medical Officer of the 7th Division, 3rd Army Corps, at the Curragh.

DR. HENRY ASHBY, of Manchester, will deliver the Wightman Lecture of the Society for the Study of Diseases in Children in May, 1905.

It is officially announced that the Emperor of Germany has acceded to the request of Professor Dr. Robert Koch to be relieved of his post of Director of the Institute for Infectious Diseases, with a retiring pension. Notwithstanding his resignation, it is understood that Dr. Koch will remain in the service of the

State for purposes of research work, and in the course of the coming winter he will proceed to German East Africa to carry out certain bacteriological studies there.

DR. WILLIAM MARTIN, for over forty years physician to Jervis Street Hospital, Dublin, has, we understand, tendered his resignation.

DR. BRIEN O'BRIEN has been appointed medical officer to the Irish Constabulary of the Belfast District, in succession to Dr. W. B. McQuitty.

### Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

#### BELFAST.

ULSTER MEDICAL SOCIETY.—A special meeting of this Society was held last week to elect a President for the ensuing two years in place of Professor Lorrain Smith, who was elected at the annual meeting in June, but who has resigned his post on leaving Belfast for Manchester. Dr. William Calwell was unanimously elected to the post, and as he has been for a number of years one of the most active members of the Society, frequently reading papers and showing cases, there is no doubt that the Society will flourish under his rule. The winter session will open in November, and it is expected that the bust of Sir William Whitla will be unveiled at an early date in the session.

THE SMALL-POX OUTBREAK.—After an interval of several weeks, in which it seemed to have been stamped out, small-pox has appeared at two different parts of the city last week, a man and a child being affected. Both were, of course, removed at once to the hospital at Purdysburn, where the man has died. The families in both cases have been isolated at the intercepting hospital at Twin Island. One or two cases have occurred in the country towns of Ulster during the week, but active measures are being taken everywhere the disease appears, and there is every reason to hope that it will soon be entirely stamped out.

### Correspondence.

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

#### WHAT IS "INSANITY" ?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The interesting table talk which Dr. Robert Lee describes as having taken place at the house of the late Dr. Forbes Winslow, and at which the deceased gentleman is represented as having expressed the opinion "that nearly all the world was insane," appears to me to afford admirable corroboration of my contention as to the necessity of a legal or practical definition of insanity.

A short period ago I ventured to define insanity in its comprehensive or theoretical sense as "a greater or less deviation from reason," which definition would, of course, embrace superstitious and imaginary ideas treated as realities but unsupported by generally accepted evidence. Now I apprehend Dr. Forbes Winslow gave vent to the opinion just recited as applied to those such as my definition would include. If my conjecture be correct, I venture to say there are numbers of observers of the human mind who would agree with the deceased gentleman. Why, therefore, should Dr. Lee regard the late gentleman's opinion as "very amusing" ? Further, if it be necessary in order to convey a meaning of insanity in its comprehensive aspect to formulate a definition—I do not assert it is—but assuming the necessity for argument's sake, how much more necessary must it be to define insanity in its legal or more contracted sense.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, September 29th, 1904.



## THE "MEDICAL REGISTER."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the interests of the profession, may I ask you to be good enough to draw attention in an early issue to the importance to practitioners of keeping their addresses correct in the "Medical Register"?

The chief points to which I should like to call attention are:—(1) The Register should not be confused with the Medical Directory, as is so often done; changes should be notified to this office by practitioners themselves, and a post-card should be received in acknowledgment.

(2) This year circulars of inquiry have been sent to all practitioners whose names begin with letters from H to O inclusive, and who originally registered at the office of the Branch Council for England; any person whose name falls within those letters who has not received a circular should communicate with this office at once.

(3) Anyone who is doubtful whether his address is correct should inquire at the office without delay.

In past years you have kindly done your best to assist me in my efforts to save practitioners from the grave inconvenience of finding that their names do not appear upon the Register because of the impossibility of getting into communication with them, and I hope therefore that you will be good enough to continue to give me the benefit of your valuable assistance in the matter.

I am, Sir, yours truly,

H. E. ALLEN, Registrar.

General Council of Medical Education and Registration, 299 Oxford Street, London, W.  
September 26th, 1904.

## MR. CORONER TROUTBECK AND HOUSE SURGEONS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Is it not time that public opinion was educated as to the relationship of the coroner to the public? As an administrative servant, his duties are clearly defined, and, just as in the case of one of his Majesty's judges, should he persistently evade, exceed, or fall short of his statutory powers and instructions, he becomes amenable to the higher authorities. The Westminster coroner, Mr. Troutbeck, has, in the opinion of many persons, exceeded his powers by employing Dr. Freyberger. He has persistently flouted the general practitioner, whom he has replaced by a so-called "expert" pathologist. At a recent inquest he explained to the jury he had called Dr. Freyberger to give post-mortem evidence in place of the house-surgeon of a hospital because he mistrusted the evidence of a young house surgeon, "perhaps" only just qualified. Does Mr. Troutbeck—self-reliant man that he is—not know that post-mortems in hospitals are conducted by skilled pathologists, about whose scientific standing and experience there can be no question whatever?

I am, Sir, yours truly,

A WESTMINSTER VICTIM.

September 27th, 1904.

## THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have followed the discussion of this momentous question from the initiatory stage of Professor Taylor's address in your columns to the present with much interest, and in reading Dr. Woods Hutchinson's article in the last number of the *Contemporary Review*, it occurred to me that one or two passages therein might appropriately be transferred to your columns as embodying certain facts for the elucidation of points raised by some of your correspondents. In the article referred to, entitled "Animal Marriage," the writer points out that every form of conjugal union which the ingenuity of man has been able to devise can be found to exist in full perfection among the so-called lower animals. "From promiscuity, through union simply for the mating season, to polygamy, polyandry, and finally monogamy and monoandry,

every possible phase and form of the institution can be studied outside of the human species. The same results appear to have been reached by experiment here as in our own species—namely, that in proportion as the species rise in the scale of aggressiveness and intelligence, promiscuity or mere mating-season union tends to disappear, and either a lasting form of polygamy, or more frequently a fairly well settled form of monogamy, in many cases even lasting for life, is reached. The progress of the forms of combination of the sexes might be expressed in the statement that the accumulations of racial experience tend to show that by the production of a smaller number of offspring and the expenditure upon these of a greater amount of parental care, better results can be obtained in efficiency and capacity for survival.

"We have living examples of every possible stage of the solution of this problem, from the production of eggs by hundreds of thousands, as in the insects and the fishes, with absolutely no parental care and a loss from enemies of 95 per cent., through the intermediate types of mammals, with their broods of from six to a dozen members, and with an infant mortality of probably not more than 50 per cent., up to the highest mammals, including man, with but a single offspring at a birth and an infant mortality of 20 per cent. And we believe that almost every individual instance will be found to be explainable by conformity to this law, in so far as circumstances permit; each progressive organism giving the greater amount of care and protection to the young, and thus causing the race to grow and progress; while each retrogressive or degenerate organism gives a smaller amount of parental care than is necessary to maintain the race at its level."

Thus, according to Dr. Hutchinson, we have the voice of Nature proclaiming the fewer the better, not only for the individual, but for the community at large. But here comes in the eternal *if* to spoil the Malthusian chimera—the power of which is exemplified in everyday experience—that the members of large families are generally better citizens, more energetic and resourceful than the pampered ones and twos of limited liability.

I am, Sir, yours truly,

ONE PERSONALLY INTERESTED.

## Obituary.

## GEORGE CROKER, M.D. GLASG., F.R.C.S.I.

We regret to announce the death of Dr. George Croker, at his residence, Mount Pottinger, Belfast, on September 22nd. Dr. Croker was born in Wicklow, and studied at Glasgow, where he graduated M.D. in 1840 and four years later became a Fellow of the Royal College of Surgeons in Ireland. For a time he practised in the south of Ireland, but afterwards he became resident physician to the present Marquis of Downshire's grandfather. Later, he took up residence in Ballyhackamore, and acted as dispensary medical officer of No. 11 Castlereagh district. He leaves two sons and two daughters; one of his other sons, Dr. E. Croker, died when house physician of the Royal Victoria Hospital some years ago. Dr. Croker, who attained the age of 90 years, was greatly respected and had at one time a large practice.

## ARCHIBALD HAMILTON, M.D.

The death has taken place suddenly at Windermere of Dr. Archibald Hamilton, one of the oldest doctors in Westmoreland. He took his degree at Edinburgh University in 1861 and came to Windermere as an assistant to the late Dr. Cowes. Dr. Hamilton was a Conservative, and at one time president of the Windermere Conservative Association. His bright and humorous speeches are well remembered. He was a county magistrate and a member of the District Council. It was largely owing to his efforts that the purchase of the Queen's Park Recreation Grounds was effected. He was also one of the organisers of the Windermere Art Exhibition held last year.

MR. W. J. LE TALL, M.R.C.S.ENG., L.S.A.

WE regret to announce the death of Mr. William James Le Tall, who died recently at his residence, Hackenthorpe, after several weeks' illness. Deceased was the son of the late Dr. Benjamin Le Tall, of Newton Croft, for many years surgeon at Woodhouse. Deceased was medical practitioner for Woodhouse, but some years ago he retired, and lived at Hackenthorpe. He was 64 years of age, and had been connected with the Woodhouse branch of the Society of Friends practically all his life. He held the qualifications of M.R.C.S., L.S.A., which he took in the year 1862.

WILLIAM WHAMOND, M.D.GLASG., L.F.P.S.  
GLASG.

DR. WILLIAM WHAMOND, one of the oldest medical practitioners in Jarrow, has succumbed at his residence Balgownie, after a short illness. He qualified in 1862, and went to Jarrow forty years ago, and soon established a lucrative practice. In addition, he was the official inspector of boys at the large works on Tyneside, and attended personally to this branch of his labours to the last. The doctor was a Justice of the Peace for the borough, but seldom sat on the bench. Dr. Whamond was twice married, and leaves a widow and two young children.

BRIGADE-SURGEON EDWIN WILSON, M.R.C.S.E.

BRIGADE-SURGEON EDWIN WILSON died suddenly on the 27th ult., at Bray, aged 78. He became an M.R.C.S. Eng. in 1851, received his commission as assistant surgeon in May, 1855, rising to the rank of surgeon in 1868, and surgeon-major in 1873, and retired in 1884 with the honorary rank of brigade-surgeon. He served in the 71st Highlanders with the Central India Field Force under Sir Hugh Rose in 1858, and was present at the battles of Koonch and Golowlee, the capture of Calpee, the action of Morar, and the recapture of Gwalior. He was also in medical charge of the flying column which was sent in pursuit of Burgore Sing. For these services he received the medal with clasp.

### Literature.

CLINICAL DIAGNOSTIC BACTERIOLOGY. (c)

THIS book, it is stated in the preface, is intended for the many practitioners who have not had an opportunity of studying in a laboratory or who have not the necessary equipment for bacteriological work. For such persons, however, the seventy-six pages devoted to an examination of the acid-fast bacilli can have little practical value; and in the strictly clinical part of the work the methods recommended are in many cases of so delicate and elaborate a character as to necessitate a previous knowledge of bacteriological technique, and the apparatus of a well-equipped laboratory. The absence of exact directions as to the best methods of procuring specimens and packing and dispatching these by post is to be regretted. On the other hand, Dr. Coles' book will be found of the greatest service to those working in a well-appointed laboratory, especially to senior students and resident medical officers of hospitals, who have to do the daily bacteriological examination of morbid materials from the wards or post-mortem room. With few exceptions we have found the directions given to be trustworthy, and special attention has evidently been paid to methods of staining, although we doubt if there is anything to be gained in a work of this nature in multiplying these. For instance, six methods of staining the pneumococcus capsule are given, and six of staining the diphtheria bacillus. We differ from Dr. Coles when he states that in examining urine there is little advantage to be gained by obtaining the specimen by means of a catheter, and in urine and other body fluids we believe that far better results can be obtained by a high speed centrifuge than by any form of sedimentation glass. A valuable feature of the book is the list of authorities

(c) "Clinical Diagnostic Bacteriology, including Serum Diagnosis and Cyto-diagnosis." By Alfred C. Coles, M.D., D.Sc., F.R.S. Ed. Pp. 236. London: J. and A. Churchill.

given, and here the latest and most valuable work of the best British and foreign observers has been included. With regard to the tests by which it is proposed to distinguish between tubercle bacilli and other acid-fast varieties, these will no doubt be subjected to close examination in the immediate future, and if found trustworthy will be generally adopted. In our own experience we have met with two cases in which a mistaken diagnosis was made owing to the smegma bacillus being taken for the tubercle bacillus, and such cases are not uncommon. The investigation of this matter must, however, for the present rest in the hands of bacteriological experts. The chapter on cyto-diagnosis should be read by all, for this aid to diagnosis, based on the examination of the nature and variety of the cellular elements found in an exudation, has not been as fully employed in the past as it should have been.

### Laboratory Notes.

"TABLOID" LITHIUM CITRATE AND UROTROPINE, EFFERVESCENT.

MEDICAL men who wish to administer lithium citrate in conjunction with urotropine will find "Tabloid" Lithium Citrate and Urotropine, Effervescent, an excellent preparation for the purpose. It is manufactured by Messrs. Burroughs Wellcome, and each tabloid contains:—

Lithium citrate, gr. 5 (0.324 gm.).

Urotropine, gr. 3 (0.194 gm.).

Effervescent basis, q.s.

In most cases it is clearly desirable to administer a combination of this nature in a good draught of water, in such case the effervescent properties of this product will be found advantageous. The combined action of these drugs is likely to render the particular tabloid of special value in the case of gouty patients suffering from urinary complications.

KEPLER'S MALT EXTRACT, WITH HÆMOGLOBIN.

WE have examined a sample of this well-known preparation of malt extract, received from the manufacturers, Burroughs Wellcome and Co., and have proved the presence of hæmoglobin. It is claimed that by the administration of hæmoglobin the iron contained therein is presented in a readily assimilable form, and with this statement most medical men are agreed.

The malt extract is a good one and contains somewhat less moisture than we have found in similar specimens. The sample submitted to us is remarkably free from any caramelised taste, and its flavour is excellent. These points are of consequence as they render it convenient of administration to children and to invalids.

SERRAVALLO'S IRON AND CHINCHONA TONIC.

THIS tonic forms an admirable means of administering iron and the cinchona alkaloids in a palatable form. Unlike so many preparations which claim to contain an appreciable amount of iron, we find on analysis that this preparation really does contain a quantity likely to be of value in cases of anæmia, debility, chlorosis, &c. At the same time the alkaloids from the bark successfully mask the taste of the iron and add to the value of the preparation. The basis of the preparation is a wine of good quality, and we have pleasure in bringing this preparation before the notice of our readers. The London depot is at 45, Holborn Viaduct.

MILO FOOD.

THIS food is prepared by Henri Nestlé, Vevey, Switzerland (of condensed milk fame), with a basis of dessicated milk, as is shown by its containing on our analysis 7.8 per cent. of milk-fat and a proportionate amount of milk-sugar. The remaining parts of the

food consist of cane sugar and starch, a portion of which has been partly converted by the action of diastase.

While some authorities insist that no starch whatever shall form part of the food of children under nine months of age, the proportion here given cannot be objected to, and its presence together with the maltose and dextrine will serve to break up any curd that would otherwise be formed by milk that would in all probability be given with the food to young children. The mineral matter, 1.3 per cent., is of the proper nature, consisting mainly of the phosphates of calcium and potassium to furnish the salts required for the building up of the framework of growing children. The nitrogenous, or flesh-forming properties are present in due proportion (12.1 per cent.), and the food, when mixed with milk and water, yields a uniform liquid of a slightly sweet taste and agreeable flavour, such as would readily be taken by children. The pamphlet issued by the manufacturers contains an adequate and accurate description of the composition of the food and is deserving of the attention of medical men.

## Medical News.

### THE WELSH RAILWAY ACCIDENT.—A MEDICAL HERO.

THE terrible railway accident in Wales on Monday last, when four persons were killed and many injured, will be ever memorable in the medical world for the heroic conduct of a medical man. This gentleman, according to the description of one of the passengers, took the direction of affairs into his own hands and gave orders for the smashing of doors and the cutting of holes in the roofs of the broken carriages, in order to reach the injured. His purely medical aid was no less prompt and valuable. He is described as having "worked magnificently," and as having even torn up his coat to make bandages. Before going to press we have been unable to identify with certainty this gentleman, of whom the medical profession may well be proud, but presumably he was Dr. W. Philip Jones, of Wostenholme Road, Sheffield, who was among the slightly injured.

### Death of a Medical Man from Chloroform.

AN inquest was held in Liverpool last week concerning the death of Edward Lloyd Roberts, who was in practice as a doctor at Chester with his father. On Wednesday evening he engaged a room in a temperance hotel in Liverpool. The next morning an assistant in the hotel knocked at his door several times, and, failing to get any answer, called in the police, who forced open the door and found him lying on the bed, fully dressed. He had a handkerchief in his left hand near his mouth, and was dead. In his pockets were several bottles which had contained either chloroform or laudanum. Richard Mills, a brother-in-law, said that Dr. Roberts was a teetotaler, quite steady in his habits, and he had been in fairly good health. He had been addicted to the habit of taking chloroform for the last twenty years. He had told witness that while under the influence of chloroform he had beautiful dreams and that he took it very strong. He had tried, but unsuccessfully, to break off the habit. The chemists in Chester would not supply him with the drug, but he obtained it at shops where there were new assistants or in other towns. In Dr. Corlett's opinion death was due to chloroform poisoning by inhalation, and Detective-Inspector Robertson said that he had seen Dr. Roberts on Tuesday, and at that time he was quite satisfied that he had no intention of committing suicide. The jury returned a verdict of death from misadventure, and expressed deep sympathy with the family.

### St. Bartholomew's Hospital.

THE following are the results of the recent examinations:—*Senior Entrance Scholarships in Science* (value £75 each), E. P. Cumberbatch and G. Graham. *Junior Entrance Scholarship in Science* (value £150), T. S. Lukis. *Preliminary Scientific Exhibition* (value £50),

G. Rigby Lynn. *Jeaffreson Exhibition* (value £20), K. C. Bomford.

### London Hospital Medical College.—Entrance Scholarships.

*Science*, "Price" Scholarship (£120), Mr. A. H. Penistan; *Science Second* (£60) Scholarship, Mr. C. Ilderton Wright; *Science, Third* (£35) Scholarship, Mr. Ronald Candy; *Science, Hon. Certificate*, Mr. E. B. Morley. "Price" Scholarship in *Anatomy and Physiology* (£60), Mr. R. B. Lloyd, Emmanuel College, Cambridge. *Epsom Scholarship* (£120), Mr. J. P. Little.

### Middlesex Hospital Medical School.

THE following scholarships have been recently gained:—*First Entrance Scholarship* (£100), Mr. A. O. English. *Second Entrance Scholarship* (£60), Mr. P. S. B. Langton. *University Scholarship* (£60), Mr. E. L. Kennaway, B.A. Oxon. *Freer Lucas Scholarship* (£126), Mr. E. A. Saunders.

### University of Durham—Faculty of Medicine.

THE following candidates have satisfied the examiners:—

*M.B. (final).—Honours—Second Class.*—Neville Avory Eddlestone, and Richard Woodward Swayne. *Pass List.*—Vincent Edgar Badcock, Frederick William Cheese, M.R.C.S., L.R.C.P., John Bowman Cooke, George Denholm, Sampson George Victor Harris, Florence Barrie Lambert, Arthur Cecil Hays McCullagh, Frederick Charles Pybus, George Robert Philipson, Norman Spedding, Thomas Leathard Wormald.

*Second Examination.—Anatomy, Physiology, and Materia Medica. Honours—First Class.*—Herbert Max Levinson.

*Honours—Second Class.*—Edward Percival Hearne Joynt, Charles Gordon Kemp, Roland Wilfred Pearson, M.R.C.S., L.R.C.P.

*Pass List.*—Orrock Arnott, Harold Henry Blake, Frederick William Cheese, M.R.C.S., L.R.C.P., William Harold Edgar, George Reginald Ellis, John Everidge, John Ernest Hanna, Herbert Fletcher Joynt, Stanley Dunn Metcalfe, William Rollin, James Wilkie Smith, Leslie Henry Walker, George Walker, Lionel Langford Westrope.

*First Examination.—Elementary Anatomy and Biology, Chemistry and Physics.—Honours—First Class.*—Charles Frederick Morris Saint.

*Honours—Second Class.*—Henry Glendinning Davison.

*Pass List.*—Norman St. Clair Bruce Cummins, Percy Hall, Isaiah Hodgkinson, Herbert Richard McAleenan, Satyen Mozumder, Jack Dixon Turnbull.

### Odontological Society of Great Britain.

WE are asked to announce that the above Society is prepared to receive applications for grants in aid of the furtherance of scientific research in connection with dentistry. For particulars and forms of application apply to the hon. secretary, Scientific Research Committee, Odontological Society, 20 Hanover Square, W.

### King's College and King's College Hospital (University of London.)

THE following scholarships have been awarded in the Faculty of Medicine:—*Medical entrance*, £50, E. B. Clayton and A. F. Comyn, equal; *Sambrooke*, £100, B. Hughes; *Two Warneford*, £100 each, T. H. Whittington and G. Matthews; *Epsom Scholarship* (fee tuition), H. A. Milner.

### The Medico-Legal Society.

THE third annual general meeting of this Society will be held at 22 Albemarle Street, New Bond Street, London, W., on Tuesday next, October 11th, at 8.15 p.m., when the reports of the treasurer and the secretaries will be presented, the officers for the coming session elected, and the following resolutions moved:—

(a) By Dr. W. Wynn Westcott, "That this Society shall be called the 'Medico-Legal Society of Great Britain and Ireland.'" (b) By Dr. F. J. Smith, "That the annual subscription shall be one guinea, and that a composition life subscription be fixed." (c) By Mr. R. Henslowe Wellington, "That the rule *re* the Presidency be rescinded, so that the office may be held for three consecutive years."

## 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.

**"THROAT CASE"** (Bedford).—A correspondent from Bedford has sent us what evidently is a clinical record of an anomalous case of diphtheria. Unfortunately a portion of the MS. has been lost in the post, and the only clue to its origin is the postmark on the envelope. We should be glad to have a further copy with the name and address of the sender.

### THE POOR MAN'S CHILD.

A DISTRICT nurse was sent to see a poor young patient, and wishing to examine the child and thinking a wash desirable, she asked the mother if she had a bath. "Lor, yuss, nuss," was the answer: "we've 'ad a bath in the 'ouse these seven years; but, thank God, we've never 'ad to use it!" Further inquiries elicited that the bath was regarded as medicinal, and only to be taken under doctor's orders!—"Our Hospitals and Charities Illustrated" (Kegan Paul).

J. W. E. (Reading).—It is against our rule to discuss medical subjects with lay correspondents. The Finsen treatment undoubtedly cures some cases of lupus, but for others it compares unfavourably with ordinary surgical measures. A full answer to your questions could be obtained by means of an ordinary consultation.

### THE DOCTOR ORDERED A TONIC.

MAGISTRATE to Paddy:—"I see you were arrested for stealing a grate"

Paddy:—"Sure, an' it was the docthor's fault, he towld me to take iron, and didn't I follow his advice and take a stove, bad luck to him!"

**EDINBURGH.**—The proposition that uric acid met with in man is conveyed to his tissues mainly by means of flesh, eaten as food, cannot be taken as established. The facts of avian physiology will have first to be clearly explained, to say nothing of many phenomena concerning natural and morbid uric acid formation in man. At the same time the arguments both *pro* and *con* are worthy of most careful consideration.

### PREVENTION OF CRUELTY TO CHILDREN.

THE Act of 1894 having been found during the ten years working to be defective and difficult of application, an amended Act was passed during the last Session and became law on Saturday last, October 1st. The principal Amendment aims at the suppression of the iniquitous customs of insurance of infant life, whereby the insurer gains a money premium on the death of the child. The *bona fides* of transactions of this nature will need such convincing proofs in future that it will be morally impossible for the guilty to profit by this form of so called cruelty—imprisonment being the more likely alternative.

**WEST TOWN (Berks.).**—The number is out of print—you will find the reference in any medical library.

D. P. H.—The fallacy of a low general death-rate which disguises a high infantile mortality is obvious. We are obliged for drawing our attention to the point and accept with pleasure your offer of a paper on infantile mortality generally.

## Meetings of the Societies, Lectures, &c.

### WEDNESDAY, OCTOBER 5th.

**OBSTETRICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Lockyer, Dr. Handfield-Jones, and others. Paper.—Dr. J. M. Kerr: Certain Details regarding the Operation of Cesarean Section in Cases of Contracted Pelvis, based upon a Series of 30 Cases.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. P. J. Freyer: Clinique. (Surgical.)

### THURSDAY, OCTOBER 6th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.)

### FRIDAY, OCTOBER 13th.

**HARVEIAN SOCIETY OF LONDON** (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Harveian Lecture Mr. C. B. Keetley on "Plastic Surgery."

## Vacancies.

**City Hospital for Infectious Diseases, Newcastle-upon-Tyne.**—Resident Medical Officer. Salary £100 per annum, with board, lodging, &c. Applications to the Medical Officer of Health, Town Hall, Newcastle-upon-Tyne.

**Wolverhampton and Staffordshire General Hospital.**—House Physician. Salary £100 per annum, with board, lodging, and washing. Applications to Edmund Forster, House Governor and Secretary.

**Royal Victoria Hospital, Dover.**—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Hon. Secretary, Arthur B. Elwin, Esq., 2 Castle Street, Dover.

**Royal Hospital for Diseases of the Chest, City Road, E.C.**—Resident Medical Officer. Salary £120 per annum, with furnished apartments, board, and washing. Applications to the Secretary.

**Brecon and Radnor Lunatic Asylum, Talgarh, Breconshire.**—Medical Superintendent. Salary £450 per annum, with fully furnished house, coal, light, washing, and garden produce. Applications to J. H. Evans.

**Northampton General Hospital.**—House Surgeon. Salary £100 per annum, with furnished apartments, board, attendance, and washing. Applications to C. S. Bisbee, Secretary-Superintendent.

**County Asylum, Mickleover, Derby.**—Senior Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

**Leicester Infirmary.**—Assistant House Surgeon. Salary £80 per annum, with board, apartments and washing. Applications to the Secretary.

**Essex County Asylum, Brentwood.**—Assistant Medical Officer. Salary £150 per annum, with board, and residence. Applications to the Medical Superintendent.

## Appointments.

ANDERSON, C. A., Junior House Physician to St. Bartholomew's Hospital.

BIRKETT, H. J. D., Junior House Surgeon to St. Bartholomew's Hospital.

BOWEN, M. W., Surgeon to the Royal Ear Hospital, Soho, W.

BOYLE, H. E. G., L.R.C.P.Lond., M.R.C.S.Eng., Assistant Chloroformist to St. Bartholomew's Hospital.

BREWERTON, E. W., F.R.C.S.Eng., Clinical Assistant to the Department for Diseases of the Eye, St. Bartholomew's Hospital.

BURFIELD, J., Junior House Surgeon to St. Bartholomew's Hospital.

BURROUGHS, H. N., Senior House Surgeon to St. Bartholomew's Hospital.

COCKE, M. STURGEON, M.E.C.S., L.R.C.P.Lond., Assistant Surgeon to the Royal Ear Hospital, Soho, W.

COLEMAN, F., M.R.C.S., L.D.S., Clinical Assistant to the Dental Department, St. Bartholomew's Hospital.

COLT, G. H., Junior House Surgeon to St. Bartholomew's Hospital.

CRIPPS, L., Junior House Surgeon to St. Bartholomew's Hospital.

GASK, G. E., F.R.C.S.Eng., Clinical Assistant to the Department of Orthopaedics, St. Bartholomew's Hospital.

GOULD, H. A., Resident Midwifery Assistant at St. Bartholomew's Hospital.

HADFIELD, C. F., Junior House Physician to St. Bartholomew's Hospital.

HAGGARD, T. B. A., M.R.C.S.Eng., L.R.C.P.Lond., Senior House Surgeon to St. Bartholomew's Hospital.

HEPWORTH, F. A., M.E.C.S.Eng., L.R.C.P.Lond., Junior House Physician to St. Bartholomew's Hospital.

HOGARTH, A. H., M.E.C.S.Eng., L.R.C.P., Assistant Extern Midwifery Assistant at St. Bartholomew's Hospital.

HORDBE, T. J., M.D., B.Sc.Lond., M.R.C.P., Clinical Assistant to the Department for the Diseases of the Skin, St. Bartholomew's Hospital.

MACFADYEN, N., M.R.C.S.Eng., L.R.C.P.Lond., Assistant Extern Midwifery Assistant at St. Bartholomew's Hospital.

MURISON, A. LOGAN, M.R.C.S., L.R.C.P.Lond., Surgeon to the Royal Ear Hospital, Soho, W.

NELIGAN, A. B., M.R.C.S.Eng., L.R.C.P.Lond., Senior House Physician to St. Bartholomew's Hospital.

## Births.

COLEMAN.—On September 28th, the wife of J. G. B. Coleman, M.E.C.S., L.R.C.P., Sutton Bridge, of a daughter.

GOING.—On September 28th, at Erinagh, Littlehampton, the wife of E. M. Going, F.R.C.S.Eng., of a daughter.

PINCHES.—On October 1st, at 20 Margaret Street, Cavendish Square, London, the wife of Major W. H. Pinches, R.A.M.C., of a daughter.

## Marriages.

CUTLER—PHILLIPS.—On September 28th, at St. Albans Abbey, Horace Cutler, M.A., M.B., B.C., of Broughton, Hampshire, fourth son of Samuel Cutler, of West Bank, Lewisham Hill, to Edith Maud, second daughter of Arthur F. Phillips, of Torrington House, St. Albans.

RIDDELL—WILSON.—On September 29th, at St. James's Parish Church, Dover, by the Rev. A. Howell Smith, Rector, Robert George Biddell, M.B., F.R.C.S.E., D.P.H., Rotherham, to Annie, daughter of the late James Wilson, Esq.

## Deaths.

BURMAN.—On October 2nd at 43 Nightingale Road, Clapton, William Minin, eldest son of the late William Burman, surgeon, in his 75th year.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, OCTOBER 12, 1904.

No. 15.

## Original Communications.

### HOSPITAL ISOLATION AND SCARLET FEVER: THE STATISTICAL ASPECT.

By C. KILLICK MILLARD, M.D., D.Sc.,  
M.O.H., Leicester.

Late Medical Superintendent, City Hospital, Birmingham.

IN my previous article I stated that the all-important question whether fever hospitals really were doing good could only be finally decided by appealing to statistics, and I mentioned two principal methods of applying statistics to this question. The first was to compare the prevalence of the disease *before* and *after* the establishment of a hospital. The second was to compare towns possessing fever hospitals, and treating a large proportion of their cases in hospital, with towns not possessing these institutions, and in which, therefore, all cases of scarlet fever had to be treated at home.

There are, however, other methods which may be, and have been, tried. Thus, the prevalence of the disease can be ascertained for the different wards and subdistricts of a town, and these can then be compared with one another with reference to the proportion of cases removed to hospital. This method has recently been applied by Dr. Boyd to South Shields, and the result published in *Public Health* for August. From this it appears that, speaking generally, those wards in South Shields in which the proportion of cases removed to hospital is high show a somewhat smaller amount of scarlet fever than do those where the proportion removed is lower. On the face of it this certainly appears to be an argument in favour of hospital isolation. As is so often the case with statistics, however, there is an important consideration which may entirely nullify the apparent significance of such a comparison as this. In South Shields, like other towns, there is a single sanitary organisation and a single system of hospital isolation, and the same standard is adopted in deciding which cases shall or shall not be removed to hospital.

The reason why some districts of a town show a larger proportion of removals than others is solely because the *social* condition of the inhabitants varies. In some districts a large proportion of the inhabitants will belong to the lowest stratum of society, living in small tenements in "slummy" surroundings. In such circumstances, a very large proportion of cases will usually go to hospital. Other districts will contain a large proportion of the more prosperous classes living in newer and

larger houses, and with better sanitary surroundings. In these districts a considerable number of parents will prefer to keep their children at home. Therefore, before we can proceed to deduce anything from the fact that the poorer districts of a town, isolating most, have the least scarlet fever, we must be sure that the difference in social condition is not itself the explanation. Now, although it is often assumed that scarlet fever (like typhus fever) naturally tends to prevail most in the "slummy" or poorer parts of the town, it is probable that the idea, so common with the public, that scarlet fever is associated with insanitary surroundings is only one of the many misconceptions in regard to this disease which need to be removed before we can view it in its true perspective. The origin of the belief can readily be traced to the association of ideas in connection with the term "fever." Personally, I am inclined to think that scarlet fever is naturally less prevalent in the more "slummy" parts of a town, and I may say that Dr. Boyd, in the paper referred to above, also lends support to this view. It is important that this point should, if possible, be settled, and the experience of towns where there is no hospital isolation to confuse the issue ought to enable this to be done.

Another method of using statistics to determine the value of hospital isolation, and one which has several times been adopted, is to make a comparison in a given town between the secondary cases which occur in houses where the primary case is left at home with those which occur where the primary case is removed to hospital. We should certainly *expect* that in the latter class there would be a smaller proportion of secondary cases, and this has generally appeared to be the case. *A priori*, indeed, this seemed such a very probable result that until quite recently it was scarcely challenged, and it was looked upon as a strong statistical proof of the value of hospital isolation. But Dr. Niven, of Manchester, who has devoted special attention to this subject, has recently pointed out in his Annual Report for 1903 that there is a very important precaution to be taken, and without it the results of this method are likely to be most misleading. The precaution is this: It frequently happens that cases of scarlet fever occur so slight in character that they are not at first recognised as scarlet fever, and they are therefore allowed to remain at home and no attempt at isolation is made. Such cases may give rise to several other cases in a family, and their real nature is then discovered. These overlooked cases give rise to a very high proportion of secondary cases, and unless they are carefully picked out and

excluded from the group of home-treated cases they will unfairly "weight" that group. Dr. Niven, moreover, is careful to take into consideration "return cases," a certain proportion of which always occur after the return home of the hospital-treated patients.

The following figures are a summary of an important table given on page 97 of the Manchester Health Report for 1903:—

SCARLET FEVER IN MANCHESTER, 1901-1903.  
An Abstract of Dr. Niven's table on page 97 of his Annual Report for 1903.

	Number of Primary Cases.	Number of Susceptible Persons under 15 years Left at Home	Number of Secondary plus Return Cases.	Percentage calculated upon number of Susceptible Persons under 15.
Removed to hospital . . . . .	2,681	5,040	738	14.6
Treated at home . . . . .	573	560	90	16.0
"Overlooked" cases . . . . .	214	431	288	66.8
	3,468	6,031	1,116	38.1

Although Dr. Niven is an advocate of hospital isolation, he is constrained to admit (page 102) that as regards his own figures hospital isolation shows little material saving so far as the other inmates of infected houses are concerned.

There is another method which has been very frequently employed, but which is also liable to be misleading, and this is to compare the relative *fatality* among home-treated and hospital-treated patients. On the face of it, this seems a reasonable enough method, and so long as it was believed that hospitals were accomplishing a great amount of good, no surprise was felt when it was found, as usually proved to be the case in most towns, that the fatality among the hospital-treated patients came out distinctly lower than among those treated at home. In some annual reports calculations were even made, using the relative fatality among hospital and home-treated patients as a basis, to show the actual number of lives which were supposed to have been saved through the superior treatment received in hospital. But, unfortunately for these calculations, the difference in some towns between the hospital-treated and home-treated patients came out so impossibly great that even the most sanguine could scarcely accept them. Thus, in Warrington, for the ten years 1890-99, the home fatality was 19.2 per cent., against a hospital fatality of 7.2; whilst in Huddersfield, during the same period, the figures were 16.9 against 3.2. In the latter town, indeed, in the year 1899, the figures were: hospital cases, 1.5 per cent.; home cases, 28.5 per cent.! It is clearly quite impossible to accept these figures seriously. Among the towns without isolation hospitals, in which, therefore, *all* cases were home-treated, no such abnormal fatalities are anywhere to be found. Indeed, the fatality of scarlet fever in the non-isolating towns is, speaking generally, in no degree higher than in the isolating towns. The explanation of the apparently terrible fatality in the home-treated patients in Warrington and Huddersfield is simply this: in these towns the home-treated group is a small one, most of the cases going to hospital. A few cases, however, are too ill to be removed, and are left at home to

die, and these unduly "weight" the home group. In other words, a certain amount of *selection* must inevitably take place of the cases that go to hospital and of those that remain at home, and this completely invalidates a comparison between them. Now, the same causes which have operated in Warrington and Huddersfield may be presumed to have operated, though to a less extent, in other towns, and unless we can positively exclude them, which is scarcely possible, it must obviously be most unsafe to trust to any comparison of this kind.

Moreover, there are some towns, *e.g.*, London and Birmingham, where the fatality of the hospital patients is actually higher than that of those treated at home. This also is explainable by the selection of cases which takes place, hospital patients being drawn from a different social class. There are few, I think, who would care to contend that the higher fatality of the hospital patients in London is any evidence of inferior treatment; but if the comparison is not admitted in the case of London, or wherever it tells against hospital treatment, ought we in fairness to make use of it just when it happens to tell in favour of such treatment?

Before leaving the subject, I would take exception to the contention sometimes put forward that those who have criticised the hospital isolation of scarlet fever have not yet conclusively *proved* that it is doing no good. Surely, the burden of proof in such a case as this should be with those who advocate hospital isolation rather than with those who criticise the measure. On the one hand we have men who, in spite of much admitted evidence of a most discouraging nature, still continue to advocate the building of further hospitals on the old lines, just as if they were accomplishing all that was originally expected of them. On the other hand are those who merely advocate that the whole question should be thoroughly investigated before further increasing the already large capital expenditure on hospitals.

Then, again, it has frequently been urged that those who have criticised hospital isolation have nothing better to offer in its place. Surely, this is not a valid objection. A precisely similar "objection" could have been urged against those who first criticised blood-letting or any other now obsolete but once much-vaunted measure! If a thing is doing no good, or, at least, yielding no results commensurate with the cost entailed, no substitute for it is required.

I think I have said sufficient to show that the question of the utility of fever hospitals is a highly complex one, and that many of the arguments put forward in support of it require careful examination before they can be accepted as conclusive. The same, no doubt, applies to some, at least, of the arguments used against it. The present state of affairs is eminently unsatisfactory. If it were a subject of dry scientific interest, only it would not so much matter, but unfortunately, the questions at issue are involving a large and increasing expenditure of public money which is very badly needed for many other public health purposes. As the late Sir John Simon wrote, nearly forty-five years ago, in one of his classic reports to the Privy Council, when attacking the evils of overcrowding in general hospitals: "The doings of hospitals and the relative successfulness of such doings are of great public importance; and all



questions concerning them ought to admit of being answered quite unambiguously to the public."

## INFLUENCE OF NUCLEIN IN THE TREATMENT OF BRIGHT'S DISEASE OF THE KIDNEYS AT A HIGH ALTITUDE.

By A. S. ASHMEAD, M.D.

IN a case of chronic Bright's disease treated by me in the Pocono Mountains, the camp for the treatment of consumption, Pike County, Pa., at an elevation of 2,000 feet, I record the following results:—The urine at once became very red, and continued so for two weeks. This was probably due to increase of uro-hæmatin, by the influence of the particular remedy used and the peculiarity of ozonised air of the region and its influence on the liver and blood.

An increase of drinking water or other liquid is necessary at this height, more than is required at lower elevations, where the air is less dry; and, in consequence, there is increased urination.

Meat as an article of diet is not craved here, but starches, especially potatoes, are consumed with the greatest avidity. Even a moderate supply of meat, say, once a week, proves to be too much for the system. Old residents are not quick of bodily movement—they walk slowly, work leisurely, and seem to act in everything they do in a lazy manner. This is not because they are really lazy; the peculiarity is not temperamental by any means, but it is because the air here does not permit of alacrity.

One soon adapts one's self to this variation of life's conditions, and lazy actions soon take full possession of even the alert New Yorker. This laziness is most natural; one's muscles soon tire out; sleep is the order of the day, rather than merely of the night, and especially does the feeling of drowsiness overcome one for two hours after rising. The ozonised air, the dry mountain breeze blowing all the time gently stimulates the circulation of blood in the brain's arterioles, while at the same time there is increased fulness of the veins.

Insomnia could not exist here. Nutrition is influenced naturally and quickly by the sole influence of the air, and independently of the food taken in. Tissues are thus to a great extent nourished by air rather than by food, and oxygen is required instead of meat.

Hæmatin, the colouring matter of the red blood cells, is formed in greater proportion than necessary, and an increased supply of drink is demanded to wash from the blood the over-supply. Thus matters are equalised.

Nuclein, in 10-drop doses, in diseases of the kidneys seems to help the establishment of this equilibrium. It is the only remedy, in my opinion, that will do this. Hæmatin by itself in Bright's disease is perhaps curative, but the effect of the altitude and ozonised air in producing it in greater quantity does not seem to me to last sufficiently long to effect much result, for in two weeks the urine has become of natural colour.

Even advanced cases of this disease will find immediate relief by the conjoined treatment of nuclein and altitudinal air. The diuretic effect of life at an altitude and by breathing the percentage of ozone that exists here is not due alto-

gether to the nuclein. The hæmatin itself has an influence on the albumen, even when formed in normal amount, and an increased elimination of poisonous urea results. The chief plastic element of human blood is albumen. Œdematous effusions in Bright's disease follow elimination of albumen. Any oxidising agent, astrontia salt, sulphuric or nitric acid, will produce precipitation of albumen, and ozonised air will do the same thing.

Carbonic acid, as we all know, acts as a natural stimulant to the heart or arterial system, but ozonised air, its absolute opponent, has the contrary effect, for the veins, as well as arteries, are filled to overflowing by highly-coloured blood. Nuclein, therefore, is a necessary element to add to the natural treatment for its desired effect on leucocytes. Better equalisation of the component parts of all secretions is the result of the combined treatment of altitudinal air and nuclein.

The liver is the great assimilating organ of the human economy. Albuminose, which is carried through it in its passage, is brought into contact with the hepatic cells and converted into albumen. Albuminose is never found in the hepatic vein, the exit from the liver, therefore this substance is (or should be) all converted into albumen.

In a climate like this, where so little albuminous material is required, where one craves none at all almost, a disease like Bright's disease which produces, independently of the food, more albumen than the blood takes up must necessarily cure itself if only helped by a drug which will equalise the composition of the blood. The poison of Bright's disease is urea, to be sure, a 50 per cent. nitrogenised material which is retained in the blood instead of being washed out naturally; 500 grains a day should be eliminated, or thereabouts. If too much of it is retained in the blood, we have convulsions or coma.

This substance comes naturally from the disintegration of the tissues and following much exercise; the broken-down muscular tissues form a great quantity of it. Thus in Japan a jinriksha man, after a long run with his passenger, will show in his urine a superabundance of this excrementitious substance. In this altitudinal climate the cold air blowing constantly produces an indisposition to take much physical exercise; the muscles are always lazy, so that there is induced the condition directly antagonistic to the formation of urea in the blood, and the disabled kidney is not required to excrete an excess of the material. It is given time to resuscitate itself. There is a quick betterment, not only by reconstitution of the albumen-forming process of the economy by ozone (red corpuscular element) and nuclein (white corpuscular element), but there is no increased burden to be borne by it, put upon it to eliminate the excess of urea, and the dangers of uræmia are thus averted, while the albuminuria disappears, and the amount of urine increases and washes clean and heals the diseased organ.

### Typhoid in New York.

THE Health Department of New York fears that a serious epidemic of typhoid fever is developing in the city. During the past three weeks 441 cases have been reported to the city authorities, of which seventy-four have resulted fatally. The Health Department believes there will be an increase in the number of cases during October and November, and has issued a public warning against the consumption of oysters and of unboiled milk and water.

## THE DRINKING HABITS OF UNCIVILISED AND SEMI- CIVILISED RACES. (a)

By CHAS. FORBES HARFORD, M.A. Cantab., M.D.,  
Principal of Livingstone College.

THE protection of the weaker races of the world from demoralisation by the liquor traffic has for many years past occupied the attention of a special committee, the Native Races and the Liquor Traffic United Committee. In the course of these investigations, which have been chiefly directed towards the obtaining of legislative reform, some valuable facts have been recorded concerning the drinking habits of these races which are of the greatest importance. Naturally, these habits differ in each country, often in each district, so that instances can only be quoted as examples from the most important centres, though there are certain points of general resemblance to which attention may be directed. Perhaps the most convenient method of considering this subject will be to classify the different kinds of drinks which are commonly used, noting, where possible, the way in which they are used, and the effects which they produce. They are as follows:—(1) *Non-Alcoholic Beverages*.—Water, milk, palm wine and cocoanut milk when fresh, tea and coffee, drinks made with various kinds of meal and water. (2) *Native Fermented Drinks*.—Various forms of corn beer of varying alcoholic strength, palm wine, cocoanut milk and the like which have been allowed to ferment. (3) *Distilled Liquors*.—Native spirits (especially such as are prepared in India), Cape brandy, potato spirit, prepared especially in Germany for consumption in West Africa. These classes of liquor may be taken as samples of the drinks used by the native races, especially of India and Africa, the wines, beers, and the better forms of spirits manufactured in England and other European countries being almost left out of account as they are in the main too costly for wide use. (1) *Non-alcoholic Beverages*.—Chiefly used by the races concerned with their meals, but as we are dealing mainly with the liquors which produce intoxication little need be said about them. (2) *Native Fermented Drinks*.—Palm wine and similar products do not usually contain a large percentage of alcohol, but when large quantities are taken intoxication may be produced. Sir William Macgregor estimates the strongest form of palm wine to contain less than 3 per cent. of alcohol. There are many varieties of corn beer. Mr. Joseph Orpen, of Rhodesia, has given some valuable information about different kinds of what are known as Kafir beer; one form, "leting," he describes as an acid refreshing drink of little or no intoxicating quality. "Joala," on the other hand, which is more properly known as Kafir beer, is generally made with the object of producing drink of the greatest intoxicating strength attainable by native manufacture. It is used purposely to produce its toxic effects, and is drunk in large quantities till the stomach is quite distended. It has a stupefying effect, and, in addition, produces violent headaches and indigestion, even when not mixed with spirits, which is often done. Probably drugs such as bhang are frequently added to these native drinks for purposes of intoxication, and this accounts for much of the evil produced by them. (3) *Distilled Liquors*.—Mr. H. H. Mann, M.Sc., has furnished some valuable particulars as to native spirits manufactured in India. Some of those prepared in Assam, for instance, are particularly injurious, containing large quantities of fusel oil and other specially poisonous ingredients, in some cases about twenty times as much as would be found in a properly matured Scotch whisky. This he attributes to want of supervision by the Government and the fact that the spirit is not allowed to mature. As regards the

results of the drinking of such spirits, the case of Assam may again be quoted. So serious has the situation become in that province that the Assam branch of the Indian Tea Association, represented by their chairman, Mr. Buckingham, C.I.E., have recently petitioned the Government to amend the law relating to the sale of liquor in that part on account of the serious effect produced on their native labourers, a striking evidence of the gravity of the evils complained of, and the Government are taking steps to remedy some of the abuses. Similar complaints have been frequently made by employers of labour in South Africa, and have resulted in the stringent laws prohibiting the sale of liquor to natives which have existed for some time in the territory administered by the British South Africa Company, a policy which was strongly approved of by Mr. Rhodes, which was secured for Bechuanaland by the splendid persistence of Khama, and which has been introduced in a rigorous manner into the Transvaal and Orange River Colony by Lord Milner. This latter, whilst prohibiting the use of spirits and the stronger forms of Kafir beer, permits, under certain conditions, the supply of the milder forms containing not more than 3 per cent. of alcohol. This beneficial legislation has not been extended to Cape Colony, where a pernicious form of brandy is made from grapes known as "Cape smoke." Samples of this are said to have been found to contain copper sulphate, and it appears to be particularly intended for native consumption, it might also be said for their degradation, and this produces untold harm. Unfortunately the strong views entertained by practical men in South Africa has not extended to West Africa, where immense quantities of potato spirit, manufactured in Germany for the purpose, form the largest part of the trade of Great Britain, as well as of France and Germany, with the West African natives. This spirit is frequently shipped in a concentrated form containing about 80 per cent. of alcohol, and some samples of this were found to contain as much as 4 per cent. of fusel oil. Trade gin and rum, as they are called, can have but one use, *viz.*, the intoxication of the native. No respectable European will ever touch them, and they have been known to have been used for mixing with paint instead of turpentine. They are used principally on the occasion of funerals and at festivals. It is contended that there is not so much drunkenness in West Africa as in England. There is an element of truth in this, and we can only hope that it may never become so. But the facts of the case are probably as follows:—(1) The West Africans are naturally a sober people and they do not want the drink, but are too weak to resist it if taste for drink has been deliberately encouraged by the traders of a so-called Christian country, and maintained for the sake of profit, whilst the local Governments do little to stop it on account of the revenue. (2) Drunkenness is not so easily noticed among the Africans, as they drink at home and not at public bars, so they are able to sleep off the effects before coming before the public. On the occasion of festivals, however, drunkenness is sometimes very widespread. Thus it will be seen that most of the weaker races are not naturally drunken, and the responsibility lies with professedly Christian nations. In the case of these races, especially in Central Africa, the outlook is most hopeful, as it is in dealing with children at home, in that prevention may be adopted, which in this, as in so many other cases, is infinitely better than cure. This should be our aim.

### Requests to Medical Charities.

UNDER the will of John Earley Cook, of Cobham, Surrey, who died in February last, the London Hospital receives a legacy of £2,000; St. Bartholomew's Hospital, £1,500; the Metropolitan Convalescent Institution, £1,000; Earlswood Asylum, £500; and £200 to the Margate Infirmary and to the Seaford Convalescent Home.

(a) Paper read at the meeting of the Society for the Study of nebrity, October 11th, 1904.

# THE HEADACHE OF ANÆMIA AND ITS TREATMENT.

By DAVID WALSH, M.D. Edin.,

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HEADACHE is of necessity a common occurrence, for it is a prominent symptom of nearly all the acute specific and of many chronic ailments. Sooner or later its far-reaching importance as a symptom is brought home to every physician, for there is no class of malady in which the teachings of the class-room and of the text-books need to be more carefully controlled by actual bedside experience. In some cases it is what, for want of a better term, we call "functional," whilst in others it points to grave organic disease. We have always to be on the alert for the obscurer and more serious forms, for they constitute an ever-present pit-fall of practice.

Headache is due to some disturbance of the nutrition of the brain, brought about by circumstances that differ widely in different cases. Speaking generally, it connotes either alteration in the condition of the blood or interference with its circulation in the higher centres. It varies not only in its severity and intensity, but in its situation and in the duration of the paroxysms. It may be sudden, sharp and excruciating, or it may be dull, aching and persistent. It may be so intense as to unfit the patient for work, or it may be so mild as to be felt only after exertion. Nervous headache, the result of anæmia, not infrequently affects the sufferer at intervals throughout a long life. It is the accompaniment and curse of high intellectual endowment, and is most marked when the functional activity of the brain, whether in perception, emotion, or intellect, outstrips the vigour of the rest of the body.

Headache is often associated with other symptoms, such as dizziness or vertigo, a general sense of pressure or discomfort in the head, a disturbance of cerebral function with insomnia and with attacks of nausea or vomiting. It is not the purpose of this article to consider exhaustively the entire subject of headaches, but merely to discuss that form associated with anæmia, especially in reference to the symptomatology and treatment of the same.

Reflex headaches need not be more than mentioned here, as in the individual case a correct diagnosis indicates the proper line of treatment. An example of purely reflex headache is that due to eye-strain. Many so-called reflex headaches in reality arise from other causes. In ulcer of the stomach and in constipation, for instance, headache is probably due most often in the one case to the accompanying anæmia, and in the other to toxic absorption from the bowel.

Headache is a common symptom of dyspepsia and is usually of a dull, aching character, involving both frontal and vertical regions. Depression and irritability are often quite out of proportion to the amount of gastritis and may end in neurasthenia. There is often constipation alternating with diarrhoea, a condition toxæmic in character and allied to copræmia. It often happens that even when the bowels have been relieved and the gastric irritability lessened the headache still keeps the patient awake at night. Such cases are not uncommon in middle-aged men of great mental activity, whose nervous system has been run down by anxiety and mental strain. It is found in these individuals that the hæmoglobin is subnormal and that the red cells are not only diminished in number but are small, irregular in shape, deficient in colour, and immature. The judicious administration of iron in a non-astringent and readily assimilable form usually effects a cure. With the restoration of the blood cells and the hæmoglobin value to the normal, the headache speedily ceases, the appetite improves, the irritability of temper is lessened, and there is an increase of energy and capacity for work.

That impoverishment of blood is an important element in many cases of migraine or sick headache, and that treatment directed to improving the con-

dition of the blood is the proper step, are points illustrated by the following cases:—

CASE I.—M. B., a woman, æt. 30, had suffered from migraine for over ten years, the attacks coinciding with the occurrence of the menstrual periods. She had had much treatment, including arsenic, gelsemin, butyl-chloral hydrate, and various courses of Bland's pill, but without benefit apparently. She was not anæmic in appearance, but on examination the red blood corpuscles were found to number only 3,600,000 per c.mm., the hæmoglobin estimate being 46 per cent. She was given iron-vitellin, and in ten days her red cells rose to 4,700,000, and the hæmoglobin to 66 per cent. There has been no recurrence of the migraine, and the patient is now apparently perfectly well and has had no attack for three months. Many cases of migraine or sick headache are associated with anæmia. The attacks are of a paroxysmal or intermittent character, the seizures usually incapacitating the patient for three or four days at a time.

CASE II.—A governess, æt. about 26, suffered from periodical attacks of migraine or sick headache, induced by excessive brain-work, over-anxiety, and long hours, combined with deficiency of bodily exercise, short restless nights and disturbed sleep. The seizures were paroxysmal or intermittent in character, and occurred usually every three or four weeks, incapacitating the patient one to three days at a time. The headache was severe and was accompanied by loss of appetite, nausea and vomiting. The patient suffered from dysmenorrhœa, and the attacks usually preceded the onset of the menstrual period. It was noticed that the susceptibility to the migrainous attacks was aggravated by anything tending to lower the general standard of health, such as dyspepsia or constipation. The patient had had much treatment extending over a long period of years, the remedies prescribed, with little or no benefit, including arsenic, phosphorus, Bland's pill, gelsemin, butyl-chloral hydrate, phenacetin, &c. The patient presented no very obvious signs of anæmia, but a blood examination showed that the red cells were only 2,500,000 per c.mm., the hæmoglobin being 36 per cent. It was found impossible to improve her hygienic condition or obtain for her a cessation of work. She was given iron-vitellin three times a day for three weeks, and at the expiration of that time the red cells had increased to 4,600,000 and the hæmoglobin to 61 per cent. Her general condition was markedly improved, her appetite was increased, the periods were less profuse, and for three months the attacks of migraine have been so slight as not to incapacitate the patient for a single day.

The commonest form of headache met with in practice is that in which the subjective and objective symptoms of anæmia are striking and easily recognisable. In these cases the headache is usually vertical as regards situation, although it may now and then be frontal. It is due to the fact that the brain is supplied with blood which is deficient in quantity and poor in quality. Patients suffering from it are often drowsy in the upright position but wakeful in bed because the blood fails to distend the cerebral arteries during the day but flows into them at night. In some cases not only is the blood poor in quality, but it also contains abnormal and toxic constituents. The result is a condition of arterial spasm which may give rise to sudden loss of consciousness. It is the converse of the plethoric headache met with in elderly men who are free livers with regard to food and alcohol, and who from want of sufficient exercise suffer from constipation and deficient urinary secretion. The subjects of chlorotic headache are usually young women, although the condition is by no means uncommon in middle-aged spinsters. That iron is the most efficient remedy in these cases is illustrated by the following notes selected from a series of similar cases which have been treated in exactly the same manner.

CASE III.—A married woman, æt. 24, suckled her first child for six months, and for two months subsequently suffered from paroxysmal headache, the pain being situated over the brows and in the eye-balls,

which, she said, seemed too large for the head and as if they would be forced out of the skull. There was tachycardia, but there was no actual prominence of the eye-balls and the thyroid was not enlarged. The patient presented the ordinary signs of anæmia with palpitation and shortness of breath on exertion. The red blood corpuscles numbered 2,560,000 per c.mm., and the hæmoglobin value was 34 per cent. The patient was given iron-vitellin three times a day, and four days later the red cells were 2,750,000, the hæmoglobin value being 38 per cent. A week later the red cells had risen to 3,400,000, and the hæmoglobin value was 42 per cent. At the expiration of twenty-one days from the commencement of treatment the red cells were 4,200,000, and the hæmoglobin value was 82 per cent. The headache rapidly improved and at the expiration of the three weeks' course of treatment had entirely disappeared. The typical consulting-room case of the character just recorded is that of a young woman of white or greenish tint, who complains of weakness, constipation, and amenorrhœa. An examination of the blood reveals a marked diminution of the red corpuscles together with a deficiency of hæmoglobin, perhaps to the extent of 50 per cent. or more.

The two following cases illustrate headache due to anæmia arising from different causes:—

CASE IV.—A married woman, æt. 36, the mother of four children, after enjoying many years of uninterrupted good health, suffered from a profuse vaginal discharge followed by chronic arthritis, possibly gonorrhœal in origin. Under the influence of salicylate of sodium the joint trouble subsided, but was replaced by brachial neuralgia and frontal headache, worse at night and of so severe a character as to interfere with rest. Iodides in large doses were tried in vain, and other remedies, such as aconitine and gelsemin, afforded but temporary relief. The patient was distinctly anæmic, the tongue was large and flabby, and there was little or no appetite. A month spent at a bracing seaside resort, although it improved the patient's general condition, failed to relieve the neuralgic pains in the arm and aggravated the cephalalgia. Iron-vitellin in half-ounce doses was then ordered, at first without apparent benefit, but after six weeks' treatment the symptoms gradually subsided, and the patient made an excellent recovery, the leucorrhœa giving no further trouble.

CASE V.—A man, æt. 48, who had had many attacks of malarial fever in India, and for many years had indulged freely in alcohol, sought advice for persistent headache of a throbbing character. He showed signs of advanced arterial degeneration and was evidently suffering from granular contracted kidney. The urine had a specific gravity of 1007, contained a fair amount of albumin with a few coarse granular casts. The patient was dieted, his nitrogenous food being reduced to the minimum, and he was given directions with respect to the general care of his health and systematic exercise. His condition improved, but the headache was persistent and was a source of considerable discomfort. The patient was then placed on iron-vitellin, and at the expiration of a week there was a distinct lessening of pain. After a month the headache ceased, there being concurrently an improvement in the condition of the urine, although a trace of albumin remained.

So far as the treatment of anæmia is concerned, apart from measures such as pure air, liberal diet, good surroundings, and regulation of the bodily functions, hæmatinics are the only remedies that need be discussed. They are not medicines, but foods. There are many reputed hæmatinics, but iron is the only member of the group which is practically efficacious. Phosphate of lime, arsenic and manganese are of little or no avail in this connection, and are not true hæmatinics. Under the influence of iron in anæmia the cheeks grow rosy, the lips and mucous membranes are restored to their normal character, the eye brightens, the tongue cleans, the digestive organs are invigorated, there is an increase in body weight, a development of muscle and improved nerve action. The modern tendency is to discredit arsenic and manganese more and more in the treatment of anæmia. Physicians agree that success depends to no small extent upon the particular preparation of iron

that is used. That fact has been abundantly proved by experience with the old-established and classical remedies for anæmia, namely, the tinctura ferri perchloridi, the sulphate of iron, Blaud's pill, and the aloes and iron pill of the British Pharmacopœia. These astringent preparations of iron are placed at an immediate disadvantage by the fact of the close association of constipation with anæmia. Clearly, it is undesirable to administer drugs that have an astringent or constipating effect, even though such an effect may be to some extent reduced by combining the astringent iron with a laxative, as in the familiar *mistura ferri aperiens* of hospital practice. But whatever the uncertainty that surrounds the chemical changes undergone in the passage of inorganic iron from the intestine to the blood, there can, on the other hand, be no question as to the ill effects produced by astringency upon the digestive, the absorptive, and the expulsive functions of the gastro-intestinal canal.

Taking the chief preparations of inorganic iron one by one, we find that Blaud's pill often increases constipation and headache. The tinctura ferri perchloridi does the same, and in many cases irritates the delicate mucous membrane of the stomach, probably by coagulating the albumen of the gastric contents and of the mucous lining cells, besides constricting the capillaries of the stomach wall. It has always seemed to me that not a few ulcers of the stomach in anæmic women may have been caused by the prolonged action of astringent iron remedies to which they have been subjected. Otherwise, why should a patient actually develop gastric ulcer during a long-continued course of iron? Instances of that kind are familiar enough in hospital practice. If astringent iron upsets a healthy stomach, as it often does, it is likely to act far more injuriously upon a weak, anæmic organ. The objection of astringency applies also to the sulphate of iron, whether given in the form of mixture or of pill. In Blaud's pill, the iron is comparatively non-astringent, but its administration is often most disappointing, and it certainly increases constipation and headache in some cases. The old-fashioned aloes and iron pill is undoubtedly effective in many cases of amenorrhœa. As a temporary remedy, it is often of value, especially in full doses of ten or fifteen grains daily. I have known a patient, however, keep on with these pills for nearly two years, to the great detriment of her health. Lastly, a good deal of harm may result from setting up a chronic congestion of the female pelvic organs.

Organic iron approaches more or less closely the form in which iron is absorbed from ordinary food. From that point of view the administration of egg-albumen or of spinach, or of other iron-containing foodstuffs, would alone suffice to cure anæmia. Experience, however, has long shown that for some obscure reason it is necessary to give iron preparations in doses far exceeding the capacity of intestinal absorption.

The difficulty so far has been to obtain a true organic salt of iron, but the problem appears to have been solved in the production of iron-vitellin, a tasteless and non-astringent preparation, which increases the appetite and possesses well-marked hæmatinic properties. It improves in a remarkable degree the condition of the blood, increases the red cells at the rate of 100,000 a day or more and the hæmatinic value from 1½ to 2 per cent., a result far in excess of that resulting from the administration of any form of inorganic iron. Its chief clinical advantage, however, is that it has a general stimulating influence upon the processes of nutrition, thereby exerting a tonic and reconstructive action which I have never observed from the use of any other form of iron.

In conclusion, the point I desire to emphasise is this: Anæmia is the causative condition of many of the most frequently encountered cases of headache, although in many instances the impoverishment of the blood may not be apparent from the general appearance of the patient. Blood examination, however, and a careful analysis of the symptoms, will reveal marked deficiency in the percentage of the hæmoglobin or red blood corpuscles, and one or more subjective symptoms of anæmia. So frequently is this the case that it is

well to examine each patient with headache from that standpoint and to begin the administration of iron, preferably in the form of iron-vitellin, along with the preliminary hygienic and dietetic measures. This has been my practice for some time past and I have had every reason to be satisfied with its results.

## Special Articles.

### LUNACY IN IRELAND.

THE Annual Report of the Richmond District Asylum, Dublin, which has recently appeared, is in every respect an interesting document, and in view of the serious increase of lunacy in Ireland is one that deserves careful study by all interested in the future of the country. If it were only on account of the personality of the Medical Superintendent, who, no matter what his subject, always attracts and retains the attention of his readers, the Report would be of value. In the present instance, however, the facts themselves are of primary importance, though they gain much as food for study by Dr. Conolly Norman's setting and by the addition of his opinions based on them. The increase of lunacy in Ireland, which is causing grave and well-founded alarm at the present day, is unfortunately shown by the steady increase in the number of patients in the Richmond Asylum and its branch at Portrane. During last year there was an increase of one hundred and thirty-nine cases. At the same time it is pleasing to find that the number of admissions during 1903 does not show any advance on that during 1902—the figures being respectively 658 and 662. The number for 1902 was, however, higher by 142 than the highest figure ever reached previously. As in recent years, the cases admitted were mostly of a very unfavourable nature as regards prospect of recovery, many of the patients being in broken health physically, and afflicted with incurable types of mental disease. Suicidal tendencies were more marked than usual, and some interesting cases occurred in which persons with suicidal impulses presented themselves for admission as voluntary patients. Under such circumstances we congratulate Dr. Norman and his staff on the fact that no case of suicide occurred during the year. A freer mode of treating the depressed is practised in the Richmond Asylum than is thought permissible in most other institutions, and it speaks well for the intelligence and tact of the subordinate staff that it is so successful. We are pleased, too, to note that it has not been necessary to resort to restraint on any occasion during the year. Dr. Norman holds very similar views to Dr. Clouston on the importance of alcoholism as a cause of insanity. Of 394 cases for which one probable cause of the condition is assigned, in 127 it is drink. On the other hand, sexual intemperance, which is given a preponderant place in many causal tables, is not here assigned as the cause of a single admission. Hereditary influences are made accountable in 82 cases, but we fancy a much higher figure would have resulted if an accurate family history were in every case available, and if other stigmata were taken into account beside actual previous insanity in the family. The mortality in the asylum during the year is not unduly high—7.9 per cent. on the average number of patients,

but some of the causes seem capable of diminution. Phthisis, especially, is responsible for a greater proportion of the deaths than seems necessary if modern preventive and therapeutic measures are practised, though it must be remembered that it is a disease which in an insane person is very likely to advance far before suspicion is roused. Dysentery also still claims its share of deaths, and typhoid fever, though almost unrepresented in the mortality list, is present in the female house every year. It is interesting to note the variety and number of the industrial occupations in which it has been found possible to engage the great majority of the patients. All the clothes worn in the asylum have not only been made on the premises, but the stuff itself has there been woven. One can hardly think of any occupation from chimney-sweeping to "drawn-thread work," from blacksmith's work to embroidery, at which some of the patients are not employed. The importance of this steady industrial spirit is, from the point of view of economy, great, but far greater when one regards it as a rational, satisfying, and successful method of treatment.

### THE CENTRAL MIDWIVES' BOARD.

THAT curious body—the Central Midwives' Board as at present constituted—met again after an interval of quietude on the 29th ult. There were in attendance a Chairman (Mr. E. P. Young), two ladies (Miss Wilson and Miss Oldham), and a medical man (Dr. Sinclair). The meeting commenced with a discussion on a letter from a medical practitioner. This gentleman wrote to complain of the conduct of a registered midwife, to whom he had written that it had come to his knowledge that she was interfering with his treatment of a child under his care, and that if she continued to do so he would take legal action. The midwife had replied, "You may take legal proceedings whenever you like. It is much like your 'impotence' to write to me, so please mind your own business." This poor woman, who is perhaps only imbued a little too strongly with the spirit of the Board which governs her, is to have her conduct inquired into by the local authorities before the C.M.B. will interfere. We are sure that an excuse will be found for her; after all, imitation is the sincerest flattery. The next business was the reading of a letter from the London Obstetrical Society, informing the Board that the certificate of the Society had been removed from a certain midwife. The C.M.B. decided that evidence should be demanded in support of the charges against the midwife. The Board was next asked to become an architect and to give its valuable opinion regarding the suitability of lying-in wards at Brentford. This it decided to be by the vote of two ladies to one medical man. The Board then discussed the question of the compensation of midwives who were suspended to prevent them from infecting their patients. It was suggested that the Board should promote legislation to such an end, and it was decided that a note should be made of the necessity for so doing, again by the vote of two ladies to one medical man. Dr. Sinclair next asked that the statement of accounts should be sent to the members of the Board a week before the meeting, in order that members might have an opportunity of becoming acquainted with them. At this, the ladies became nervous, and thought that at the discussion of such an important question the presence of Mr. Heywood Johnstone was essential, and must be awaited. After an apparently lengthy discussion, it was, however, ruled by the Chairman that the suggestion made by Dr. Sinclair was unnecessary, and that the present system of springing the accounts on the meeting was sufficient. Accordingly, Mr. Johnstone's presence was dispensed with, and the Board adjourned until October 11th.

## THE EXAMINATION OF WATERS. (a)

Books on this subject are, perhaps owing to the limited demand, not very numerous, and, with few exceptions, those that are in use are out of date, owing to the rapid advance of knowledge in this direction; consequently, a book written by Dr. Thresh, who has acquired a reputation in the subject of water supply in its manifold bearings, is sure of a welcome. It is nothing new to medical officers of health, and to analysts, to be told that an examination of the source of supply of a water often affords more important information than could be obtained from analytical or bacteriological examinations, as these only show the condition of the water at the time the sample was taken, while an examination of the immediate neighbourhood of the source of supply may, and usually does, show the chances of possible pollution. In his preface the author says: "In numerous instances I have had to investigate supplies which have been the cause of outbreaks of disease, and in many others to investigate the cause of some change rendering the water objectionable in character. In nearly all such cases I have found that the examination of the source of the water afforded information without which the chemical, bacteriological, or microscopical examination of the water could not have been correctly interpreted." We think that this must be a slight exaggeration; coming as it does from one who has had much experience in the analysis of water, while the many and varied instances given in the book of the value of analysis seem to contradict this. On the contrary, Dr. Thresh seems to have shown more conclusively than we have seen elsewhere that the chemical, bacteriological, and microscopical examination of a water is usually sufficient to condemn it or even to pass it, when the few details asked for by the analyst as to the depth and nature of the well are answered, though, as we have previously remarked, possibilities of pollution are sometimes revealed by an examination of the source of supply. Our experience is similar to Dr. Thresh's in the discovery of sources of pollution by microscopical examination, which had been overlooked at a careful inspection. All persons acquainted with the subject will also agree that "much more skill and care (in the analysis of water) are requisite to obtain concordant and accurate results than is generally imagined."

"The chief object of the work, however, is to show how to examine sources of supply, and how to use the information thus acquired, in the interpretation of results obtained from the examination of the waters yielded by these sources, and to demonstrate that it is more important to consider the quality than the quantity of the organic and inorganic constituents found in waters from whatever source derived." The condemnation of standards is the view adopted by all who have had any experience in the analysis of water. Dr. Thresh remarks, "Standards may be useful to the beginner and the inexperienced," the logical sequence being that only those falling in this category—we have all been included in it at some time or other—patronise standards.

His book is divided into three parts:—(1) The Examination of the Sources from which the Water is Derived; (2) Various Methods of Examining Water and the Interpretation of the Results; (3) Analytical Processes and Methods of Examination. In reading the first of these parts, in which the author is at his best, one cannot help admiring the excellent way in which the subject is handled. It is well written, illustrated with numerous and aptly chosen instances of the cases in point, and forms interesting as well as instructive reading. The examination of shallow and deep wells, springs, surface water supplies, rivers and streams, service reservoirs, water mains, &c., is well described; and though much

of the information is not new to those acquainted with the subject, yet it is necessarily included to ensure a better appreciation of the many details that will be new to not a few readers.

In the second part Dr. Thresh is touching a delicate subject and adding fresh fuel to the controversy which, for the sake of the professions interested, we are glad to see going on. There is probably no one so without bias that he looks on the question of the relative values of bacteriological and chemical analyses with an impartial eye. Some lean one way, some the other. The more bigoted do more than lean—they boldly declare that there can be no possible advantage in performing a bacteriological or chemical analysis, as the case may be; in fact, to do so is likely, if not certain, to be misleading. In most cases this is due to lack of experience of the processes they so freely condemn. We have here a book written by one who, from his experience in both chemical and bacteriological methods, ought not to be biased, but Dr. Thresh is human—his book reveals it—and although he nearly takes the *via media* (proverbially the safest), he has a slight, but still an apparent, leaning towards the bacteriological side of the controversy. Nevertheless, he is very fair. "There is now a general opinion that a bacteriological examination is more important than a chemical analysis. This is undoubtedly true in some cases, but not in all. . . . When we find that waters used for long periods by large communities are condemned by bacteriologists as being dangerously polluted, and that the results obtained from the same water by different bacteriologists differ to an extent which is impossible in a chemical analysis, our faith in bacteriological examination is somewhat shaken." And again: "It is obvious, therefore, that chemical and bacteriological examinations have their special uses, and that one can rarely replace the other," but (p. 133) "bacteriology can tell us but little, if anything, of such past pollution."

Dr. Thresh lays much stress on the colour of a water. "The medical officer of health or sanitary inspector making inspections of districts supplied with water from shallow wells or similar sources of supply may be guided in their selections of samples for analysis by viewing some of the water in a deep tumbler placed on a sheet of white paper. Those in which a yellow tint is observed are the most likely to be impure." Though this in many cases, perhaps in most, may be true, it is misleading, inasmuch as it seems to suggest that absence of yellow colouring (in such a short vessel as a glass) would render it very probable that the water was pure. We should hesitate very much to say that this very slender piece of evidence was sufficient to justify neglecting to have the sample examined. Surely, if the expense of having all the samples fully analysed was prohibitive, it would be better for the M. O. H. to do as he is elsewhere urged—examine the source, and if that did not afford sufficient grounds for rejecting the water, partial analysis might be contracted for, or even the cheap process described in "A Simple Method of Water Analysis" would be better than trusting to the colour.

A readable chapter is the "Interpretation of Results of Chemical Examination," in which several matters are mentioned which will be news to many, such as the assurance that there is no vestige of proof in the hakeneyed instance of the increased prevalence of rickets in Glasgow being due to the use of the proverbially soft Loch Katrine water. Dr. Thresh has ceased to determine the hardness of water to less than half a degree, since, as he says, the same examiner sometimes gets slightly different results on the same water, even when using the same solutions. While scoring standards, as we all do, Dr. Thresh wisely gives figures suggesting what amount of the different constituents of water would indicate or suggest sewage pollution, but he seems to allow rather more latitude than most analysts.

We regret we cannot support Dr. Thresh in his statement that "practically all the information

(a) "The Examination of Water and Water Supplies." By John C. Thresh, D.Sc.Lond., M.D.Vic., D.P.H.Camb. Pp. 460, and xvii, 10 plates, 11 illustrations in text and 20 tables. 14s. net. London: J. and A. Churchill, 1904.



necessary may be obtained by an analysis made as described by me in a pamphlet entitled, 'A Simple Method of Water Analysis.' If, even after a careful and complete chemical and bacteriological analysis, it is sometimes difficult, even impossible, to offer a definite opinion on a water, and if one is still more often unable to say anything definite about a partial chemical examination, is it not possible, nay probable, that results obtained in the manner described in the pamphlet referred to will in most cases be misleading, and tend to do anything but raise the opinion of lay persons as regards the value of water analysis?

A welcome section is that on the bacteriological analysis of water; we know that the author has gone to considerable trouble to sift the apparently conflicting mass of literature on the subject, and favoured as he is with great opportunities for comparing the results of his laboratory work with the knowledge obtained from inspection of the sources of waters, he should be in a position to indicate to those not so favoured what are the best and most trustworthy methods. We have performed the bacteriological analysis described in the book, and we confess ourselves indebted to Dr. Thresh for the schemes he suggests for the search for *B. coli communis*. The subject is, however, capable of being greatly developed, as it is yet in its infancy, but we think that the author has to a great extent justified his claim as to the merits of bacteriology applied to the examination of waters. There are nineteen plates dealing with the microscopical examination of water, and a feature of these is that they are mostly drawn from actual sediments met with in the course of the author's practice, and the reader is informed of the source of the deposits and sometimes of the conclusions the author has been enabled to draw from them. The book is closed by formulæ for solutions and culture media, and by notes on "Detection of Radium in Water," "Helium in Spring Waters," "The Temperature of Water," "The New Turbidimeter," "Copper in Water," "Uncertainty of Deep Well Borings," "Value of Systematic Examination of Public Supplies," and "The Question of Standards." We have little but praise for this volume, which will doubtless receive the wide appreciation it deserves.

### British Health Resorts.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

#### XIV.—BUXTON.

BUXTON lies in and on the sides of a hill-surrounded valley in the north-west corner of Derbyshire in the High Peak district. It claims to be the highest town in England, and is 1,000 feet above sea-level. The subsoil is of limestone and millstone grit. The average mean temperature is about 47° F.; the rainfall about 51 inches; and the mean relative humidity is about 83 per cent. The air is peculiarly bracing, and even in summer the place is never unpleasantly hot. The water supply is excellent, and is derived from the grit-stone formation. The sanitary arrangements are good. Exceptionally attractive provision is made for the amusement and recreation of visitors. Buxton with Bath shares the distinction of being one of our chief thermal spring stations. The waters have a uniform temperature of 82° F. They contain nitrogen gas in solution, much  $C_1$  (carbonate of calcium), and numerous other salts in small quantities. (a)

Various forms of baths can be enjoyed at Buxton, and much benefit is experienced by many patients from drinking the waters, which are particularly suitable for cases of gout, rheumatism and rheumatoid arthritis. Almost all so-called "rheumatic" conditions are benefited by a course of the waters and suitable baths, particularly lumbago, sciatica, neuritis and neuralgia, forms of synovitis, cystitis, chronic

cases of glycosuria and some varieties of eczema and psoriasis.

Some chronic dyspeptics and hepatic cases are relieved. Not a few sufferers from chronic constipation, obesity and lithiasis improve much at Buxton.

For the after treatment of sprains, dislocations and fractures, and as a recruiting station after malaria, plumbism, and certain acute disorders, Buxton presents many advantages. Many nervous cases do well, and the place is well suited to the needs of certain neuroasthenics.

Buxton is not suited for cases marked by much debility. The waters and baths are contra-indicated in pyrexial cases, advanced lung and heart affections, when there is extensive renal disease or a tendency to plethora and cerebral hyperæmia. (a)

Buxton offers facilities for all classes. The well-to-do may find every comfort in the admirable hotels and hydropathic establishments, while the poor may enjoy the benefits of the place at the Devonshire Mineral Water Hospital, which affords accommodation for 300 patients. Buxton also has the advantage of being surrounded by country peculiarly attractive and well fitted for the requirements of the health seeker.

Efforts are now being made to develop Buxton as a winter resort. It is 163 miles from London, but can be easily reached by through carriages in a little over four hours (Midland Railway).

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, October 8th, 1904.

#### HYPERÆMIA IN THE TREATMENT OF ARTICULAR DISEASE.

SOME years ago Dumreicher published a case of pseudarthrosis cured by venous hyperæmia, and a short time afterwards Heferich, at the Surgical Congress, highly recommended this method in the same circumstances. Habbs towards 1885 had in the same way obtained remarkable results in cases of fracture where union was retarded. But it was in 1892 that Bier made his first communication on the treatment of surgical tuberculosis by venous hyperæmia. Relying on the cases of Rokitsansky as regards the immunity from tuberculosis of hyperæmiated tissues, he produced artificial hyperæmia in the limbs of individuals suffering from local tuberculous disease. He provoked the venous congestion by winding an elastic bandage around the central portion of the diseased limb, and left it in place several days, and even several weeks. A notable improvement was observed in the majority of cases.

Since then, Bier has published several papers on the subject modifying his method, which is now as follows:—Above the seat of the disease an elastic bandage or simply a flannel is applied. The compression must be sufficient to close the veins without affecting the arterial circulation. In order not to injure the subjacent tissues, it is sometimes necessary to use a large bandage or to interpose a slight layer of cotton wool. At each new application it is prudent to change the place of the bandage a little in order to avoid possible muscular atrophy. If the bandage is properly applied the periphery of the part swells, becomes of a bluish colour, and œdema appears; if this colour is not observed, the compression is too strong and must be eased.

The duration of the compression varies with the nature of the affection treated. If, for instance, it is a case of tuberculous disease of the joint, the bandage

(a) See "Buxton: its Waters, Baths, and Accessory Methods of Treatment," by Drs. W. Armstrong and J. E. Harburn. Bristol: Wright and Co. 1903.

(a) Consult article by the late Dr. W. M. Ord and Dr. A. E. Garrod: "The Climates and Baths of Great Britain." Vol. i, p. 528. London: Macmillan. 1895.

will be left on for four or five hours morning and evening. This treatment will be continued eight days, after which the bandage need only be applied for an hour daily. The patient should in no wise suffer from its application. The effects of hyperæmia, according to Bier, are as follows:—It relieves the pain, increases the bactericidal action of the tissues and stimulates nutrition.

Tuberculosis of the limbs and joints were the affections chosen by Bier for his experiments. Habbs tried passive hyperæmia on about 200 cases of tuberculous disease of the extremities. The results were in general very good, especially in cases that had not yet supplicated externally. A large number of chronic inflammations of the knee, the hands, and feet, which were doubtless produced by the bacilli of Koch, were so favourably influenced by the treatment that no trace of the disease could be discovered on its conclusion. Articular disease in children where the bones had not yet been affected derived unhopèd-for results from the bandage. Where the joint had supplicated, producing fistula, the treatment was much less successful. Arthritis due to gonococci, a very painful affection, leaving behind stiffness or a considerable deformity, improved rapidly by this artificial venous congestion. The pain quickly disappeared, and the after-deformity was much less than that observed by other treatments, while the function of the joint was hardly ever affected. Blecher tried the method for stiff joints after prolonged immobility, and obtained complete re-establishment of the articular function.

Bier also recommends his method in the treatment of gout, acute articular rheumatism, chronic rheumatism, chronic œdema, sprains, subacute periostitis, chronic arthritis. Hyperæmia eases pain in all these affections, and has a marked action on the absorption of exudations.

Your readers will find the following prescription of use:—

PAINFUL AFFECTIONS OF THE STOMACH.  
Stovaine (the new local anæsthetic referred to in my last), grs. x;

Syrup, ℥iv.

A teaspoonful in a little water after meals.

#### VOMITING.

Stovaine, grs. vj;

Sulph. of atropine, gr. ¼;

Hydroch. of morphia, grs. ij;

Spirits of chloroform, ℥iij q.

5 drops every 2 hours until relieved.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 8th, 1904.

At the Medical Society, Hr. Bumm discussed the SERUM TREATMENT OF PUERPERAL FEVER.

He said that as far as private practice was concerned, puerperal sepsis had not become much less frequent than formerly. This was partly due to the difficulties of effective disinfection of houses, inadequate assistance, and the circumstance that midwives were drawn from the menial classes, and partly also due to the patients themselves, who went about too long when suffering from slight hæmorrhages (miscarriages), and only called in the medical attendant when the uterine contents had already become foul. It was unjust always to put the blame on the attending midwife or nurse. We had still to fight puerperal fever. What had been recommended and done as regards washing out and even extirpation of the uterus had as yet proved ineffective. It was therefore our duty to

try a remedy that professed to strike at the root of the evil.

What prevented a united opinion being formed as to treatment by Marmorek's serum was the many-sidedness of the disease called puerperal fever. In cases of pain in general sepsis the prognosis was not difficult, and not more so in cases of purely local infection. Between these, however, lay the great number of cases that once or twice showed a high temperature with rigors, and which to our surprise recovered spontaneously. If serum had been used in such a case one was not justified in at once putting down the result to it. The speaker had principally used Aaronson's serum from Schering's factory. Careful grouping was required in estimating results.

His grouping was as follows:—

1. Septic puerperal peritonitis. Five cases treated with high doses of serum without any effect on temperature, bacterial character of the blood, or clinical course. All died.

2. Four cases of post-operative peritonitis in which there was mixed infection. All died.

3. Three cases of septicæmia. In two the blood was swarming with streptococci; these died. In the last case the temperature fell three times after injection of serum, thrombo-phlebitis of a leg took place, which terminated in recovery.

4. Three cases of septic endocarditis. All died. In one case an intravenous injection gave the impression of causing a bad result.

5. Four cases of pure pyæmia. All died. Here also there was mischief after an intravenous injection.

6. Peri- and parametric exudations. These were not treated by serum, as their onset showed that the rational way to recovery was already opened.

7. Streptococcic endometritis. Fifty-three cases. Twenty-one of these were mild cases with favourable prognosis, and were not further considered; 32 were serious cases with thick purulent deposits on the wound surface of the uterus and high fever. In 17 cases the blood was examined and in 12 streptococci were found; 5 died. In 21 cases the effect of the serum injection could always be seen on the temperature charts. This caused the subjective impression that the serum was really effective, and this impression was strengthened by objective observation. The streptococci lay in long chains between the pus cells in the lochial secretion of such cases, then short chains and many individual cocci or cocci in groups within the pus corpuscles. This phagocytosis was especially distinct after serum injection. This lent confirmation to the view that the serum supported or aided the curative powers of the organism. He had only seen harm result after intravenous injection; abscesses could be avoided by taking care that the serum was clear. It was useful in large doses only. It should be used also in cases in which from the nature of the circumstances sepsis was anticipated.

Prof. Olshausen denied that puerperal infection was as frequent as formerly; statistics were more carefully made up. It was extraordinarily difficult to decide on the value of any remedy, as the several cases with rigors occurring daily for weeks sometimes got better. He had never seen any success from Aaronson's serum, but he would continue trying.

In reply to a question by Hr. Hausemann, Hr. Bumm said that after injection phagocytosis appeared when it had been absent before the injection, and that it also appeared in the cases that went on to recovery.

Hr. Falk attributed the transient improvement seen in two cases to the injection itself, and thought that almost as much could be done by saline injection.

Hr. Freund was of opinion that the serum treatment must be continued, notwithstanding the fact that he had not with certainty seen any good from it. The speaker had done good in differentiating the various anatomical features of puerperal infection. How could it be recognised that the infection had not yet proceeded from the endometrium?

Hr. Bumm made his conclusion from inspection of the genitals, from negative examination of the blood, as well as from the absence of the usual signs of general sepsis.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 9th, 1904.

#### GUN-SHOT WOUND AND OPERATION.

AT the Prague meeting Lieblein recorded the history of a man, *æt.* 21, who was brought to his clinic in a collapsed condition, having received two shots in the breast from a revolver. The radial pulse on both sides was feeble, but Lieblein observed that the left was weaker than the right, and from this concluded that the subclavian artery on the left side was damaged, which diagnosis was confirmed the following day by a large aneurysm appearing in the infra-clavicular fossa. After this the patient seemed to improve, and nothing was done for forty hours, but a relapse having set in and the symptoms becoming ominous, operative interference was demanded. In consideration of the size and importance of the vessel he cut down and ligatured the subclavian in the super-scapular fossa. The wound was closed with tampons, and within an hour and a half after operation the patient was in a serious and exhausted condition, but afterwards recovered. Lieblein recommends this method of tying above the site of injury, as less damage is done and more security obtained.

#### METEORISM IN THE CÆCAL REGION.

Bayer discussed the present teaching in text-books of the diagnosis in the cases of closure of the large intestine. He gave it as his opinion that the meteoric distension of the cæcum was strong proof for localising the site of closure. The cæcal region was relatively weaker, but at the same time the wall of this part of the bowel had a double strain put upon it by the anti-peristaltic action of the large intestine, and at the same time a peristaltic action that met in this region. These two opposing forces produced inflation, congestion of the surrounding parts, and by the continued over-distension tore the serous part of the bowel, which soon led to gangrene and finally death. The nearer this obstruction was to the cæcum the more rapidly did the gangrene appear. Cæcal meteorism, therefore, was a reliable symptom of an obstruction in the large intestine.

Chiari agreed with Bayer in this diagnostic symbol, but thought that the cæcal wall was much weaker and had a sharp angular bend at this part of the bowel, which might, in general, be accepted as a common symptom. There were cases, however, that departed from this rule, where meteorism damaged other parts of the bowel besides the cæcum. He recently conducted a post-mortem where the meteorism was confined not to the cæcum but to the large intestine, where the distension of gas had torn the bowel in several places in the ascending colon. It might be added that the case was that of a lunatic, and that he had been throwing his hands about in such a manner as to strike the abdomen, and probably caused the rupture of the distended bowel at these places.

#### HÆMANGIOMA AND NOMA.

Springer exhibited a few cases which he had operated on with varying success. The first was a case of hæmangioma which had come in from the country. After the operation, in consequence of the bandaging a circular part of the head became necrosed through pressure, not only affecting the skin, but the muscles, periosteum and bones of the head, more particularly the frontal bones. The child had certainly been in a low condition, and the severe cachexia was probably the origin of the necrosis. The wound now is pretty well healed with an epithelial colouring, but the whole is not what was expected, notwithstanding grafting. The next case was a two-year-old boy, on which he had operated for noma that occurred on the upper lip, after an attack of measles. The morbid growth extended to the upper jaw, which he resected with the soft tissues and alveolar process. The operation had the effect of checking the further progress of the disease. He therefore commenced cosmetic operations by forming a new upper lip by taking flaps out of the under lip according to Brun's method. He exhibited another case of noma, in an adult, where the whole cheek was removed and a part of the maxillary bone resected. The meloplastic operation of Gussenbauer has now quite restored the cosmetic and functional condition of the affected part.

In the discussion that followed, the etiology of noma was examined from different points of view. Petruschky had found diphtheria bacilli in two cases of noma, which were injected into other cases and produced diphtheria, while the serum was used in the original cases with perfect success, the noma disappearing.

Ganghofner said that we were receiving daily proof that noma was not the effect of an individual bacillus, but seemed to have different causes for its origin, if not different bacilli, as the course of noma was different in its malignancy according to time and place. Within fifteen years he had seen twenty cases of noma similar to those described by Bayer on whom he had operated, with eighteen deaths. He was pleased, however, to see that the treatment by escharotics, &c., was now being abandoned for the operative method.

Springer had examined several cases of noma bacteriologically, and found in some staphylococci, in others streptococci, where inoculation failed. Removing the gangrenous parts around the growth was of no avail. The centre, though healthy, must be removed with a wide margin, as in all malignant tumours, even if the bone were affected.

### Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, October 8th, 1904.

At the latest meeting of the Interhospital Medical Association, Dr. Etvel exhibited several patients with sciatic dislocation of the hip, treated with the method first described by T. Elgart. The reducing of posterior dislocations of the hip is done as follows:—The narcotised patient is placed on the floor, his dislocated limb held over the knee of the surgeon, with the patient's knee at right angles, and the pelvis steadied by an assistant. By seizing the leg at the ankle and pressing downward the head of the femur will move upward, the surgeon's knee acting as fulcrum. Inward rotation of the femur is also practised by pushing the leg outward. With the free hand, the prominent head of the femur is seized and pressed

outward, so as to assist its gliding over the cartilaginous ring.

Salzwedel's method of treating local inflammatory processes with an alcohol compress has been modified by Beskoren in order to avoid the smarting caused by the application. He said that to this aim he adds to the alcohol an equal amount of a 1 per cent. solution of aluminium acetate, which raises the temperature of the fluid several degrees and makes it more soothing. The moistened gauze is applied directly over the inflamed area, and a piece of rubber tissue with more gauze over this. A perforated impermeable bandage is then wound around the parts.

He related also a severe case of typhoid hæmorrhage occurring in his private practice, which was virtually saved by the prompt use of adrenalin. Thirty drops of the commercial solution were given every three hours in physiological salt solution. No ill-effects were observed. Although it is improper to judge from one case, the patient had been bleeding steadily with all the other drugs.

Toxic symptoms following the use of aspirin have been already experienced and spoken of; however, the case of Frank had a peculiar interest, which rendered it worthy of emphasising. Namely, he noticed some very strange symptoms after the ingestion of one grain of aspirin. In fifteen minutes the upper lips began to swell, deglutition became painful, while pulse and respiration were very much increased. The swelling soon extended over the entire head, and was not relieved by cold applications. Somewhat later, an extremely troublesome urticaria made its appearance over the entire body. The following day all the symptoms had disappeared, and with them the attack of influenza, for which the aspirin had been given. Probably the condition was one of phenol poisoning from splitting up of the drug in the stomach, since the urine contained large amounts of phenol.

## The Operating Theatres.

### GREAT NORTHERN HOSPITAL.

**RE-EXCISION OF HIP.**—Mr. PEYTON BEALE operated on a woman, æt. about 35, who had been an inmate of the Hospital on three or four occasions, dating from the year 1887. In that year she had the head of her femur excised for tuberculous disease of the hip-joint. The wound had healed, but had broken down again, and had been scraped out several times. She now complained of several sinuses about the ischio-rectal fossa, two on the outer aspect of the hip-joint, and one about the middle of the crest of the ilium, with considerable pain both by day and night. The affected limb was about three inches shorter than the sound limb, and she was unable to put the foot to the ground. Seeing how very extensive the disease was from the number and position of the sinuses, the patient was advised that a thorough investigation should be made at the risk of a very much shortened leg, and a possible future amputation at the hip. The woman being placed on her face, a curved incision was made following the fold of the buttock, passing through the sinuses in the ischio-rectal fossa; the gluteal muscles were separated from the ilium, and the buttock was dissected up so as to form a large flap, the base of which extended from the crest of the ilium to the position of the great trochanter, care being taken of the sciatic nerves. Thus the hip-joint was exposed from behind. It was then seen that three inches of the upper end of the

femur were carious, the bone being very thin. It was therefore sawn off and removed in pieces. There were several sinuses leading into the pelvis, and there was no trace of an acetabulum to be made out. An incision was next made over and parallel to the crest of the ilium, and through it the inner aspect of the pelvis was investigated. Several pieces of necrosed bone were found and removed, and the sinuses leading through the pelvis were enlarged with a chisel and scraper so as to permit of free drainage right through. The gluteal flap was then replaced, about half a dozen sutures being inserted, and strips of gauze were placed between the sutures and in the wound over the iliac crest so as to permit of free drainage. Mr. Beale said that these cases were very painful ones to deal with, as the continuous discharge through the sinuses gradually weakened the patient, until he or she got into such a condition that scraping out the sinuses was the only thing to be thought of. This, of course, was a comparatively useless proceeding, as it was practically impossible to reach the seat of disease. He considered that it was right in the interest of the patient to attempt at any rate to reach the disease and remove it before he or she had become much weakened by long-continued discharge. The shock of such a radical operation was necessarily very severe, and it was very important that the patient should realise the risk of such an operation; but through it, at any rate, there was a chance of getting the disease away and prolonging life, whereas otherwise there was little or no hope. Such operations must always be rather risky, because vessels and nerves were found far out of their normal position, through cicatricial contraction following upon the original operation. It was necessary in this case, he pointed out, as in many others, to investigate the inner aspect of the pelvis as otherwise any necrosis in that situation could not be dealt with. After such an operation one could hardly hope for anything but a flail limb, and if the patient regained strength and the limb was found to be useless it could be subsequently removed. Of course, removal at the time, he remarked, was not to be thought of on account of the excessive shock.

### ITALIAN HOSPITAL, QUEEN SQUARE.

**IMPACTED FOREIGN BODY IN THE LOWER END OF THE ŒSOPHAGUS.**—Mr. LENTHAL CHEATLE operated on a girl, æt. 20, who had been admitted on account of having swallowed a half-crown three days previously. She was retching and vomiting, and the vomit contained streaks of blood. She vomited immediately after taking food. Examination with a bougie showed obstruction at the cardiac end of the œsophagus. A coin-catcher caught the coin, which, however, was so firmly impacted that a sufficient force of traction to remove the foreign body was not deemed advisable. After admission the temperature was 101° at night, and the pain in the chest went on increasing. Mr. Cheatle's colleague, Dr. Naumann, kindly X-rayed the case and demonstrated the coin in the gastric end of the œsophagus. The abdomen was opened in the middle line above the umbilicus, the stomach brought out on to the abdominal wall, and a curved longitudinal incision made midway between the two curvatures in the anterior wall of the viscus. The lips of the wound were held up and apart, and the gastric contents removed by means of sponges. The stomach was next put back into the abdomen, and the finger inserted into the œsophagus through the

gastric opening. The coin could just be felt. Curved laryngeal forceps were passed along the examining finger, the coin seized, and easily pulled downwards. The stomach wall was sewn up as follows:—The mucous membrane was joined by silk sutures, the muscular and peritoneal coats were brought together by Halsted's sutures. The abdominal wound was closed in the usual way. Mr. Cheatle said that as it had not been safe to leave the case any longer, for the temperature was rising, the pain increasing, and the patient starving, and as it was dangerous to endeavour to pull the foreign body upwards with the coin-catcher on account of the very firm impaction, he had no alternative but to attempt its removal from below. He pointed out that he had easily found the œsophageal opening in the stomach by passing his finger upwards along the lesser curvature of the viscus, until the œsophageal opening was reached; unless some method of this kind be adopted, the œsophageal opening is surprisingly difficult to find.

The girl went out of the hospital after a fortnight perfectly well.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, OCTOBER 12, 1904.

### HOSPITAL ISOLATION AND SCARLET FEVER.

THIS week we publish the last of our series of papers dealing with the question of the utility of hospital isolation as a means of controlling the spread of scarlet fever. Every one of our contributors has either openly stated, or strongly suggested, his disbelief in the ability of isolation hospitals to accomplish the purpose named. For ourselves we can hardly go so far. Though convinced of the necessity of a searching inquiry into the whole matter, we cling to the belief that isolation must prevent a certain number of attacks of scarlet fever, and that by so doing the hospital system must be credited at least with accomplishing

a certain amount of good. Whether that good is commensurate with the financial outlay involved it must be confessed is open to doubt, and this would clearly form one of the pertinent questions for a Commission of Inquiry to decide. Most of our contributors have fastened on scarlet fever as the disease towards which the light of inquiry should be turned, but Dr. Marriott, who deserves the credit of having first had the courage to open up the subject of the doubtful utility of isolation hospitals, pointed out in our last issue how difficult it would be to confine attention to one disease. The considerations that militate against success for the system in dealing with scarlet fever operate in no small degree in the case of diphtheria, and there is little evidence that typhoid fever outbreaks are appreciably prevented by the conveyance of individual cases to hospital. But in the two latter maladies the therapeutic gain to the patient is undeniable, to say nothing of the virtues of strict disinfection, good nursing and careful medical supervision which are admittedly essential to the proper treatment of all but the most benign cases of diphtheria or typhoid fever. In the bulk of scarlet fever cases it cannot be pretended that nursing or physicking plays any important rôle in the recovery of the patient, and the figures presented by Dr. Hubert Biss in his first paper showing the comparative mortality-rates for home- and hospital-treated cases for London give little warrant for the assumption that scarlet fever patients in general gain much from hospital methods. Moreover, there is a large class of doubtful cases and of mixed infections which is so intimately related to scarlet fever on the one hand, and to diphtheria on the other, that no inquiry could afford to leave them out of account. In contemplating the whole matter the mind must clearly distinguish for itself the two issues—the preventive influence of the hospitals, and the machinery for individual treatment which they afford. The two questions are distinct. It is one thing to argue that the poor should be provided with accommodation for their infectious sick when this cannot be arranged for at home, and quite another to demand that *nolens volens* every one of their number who suffers from a mild attack of scarlet fever or diphtheria shall be hurried into hospital for six or eight weeks. It may be, and we are quite prepared for the conclusion, that hospital facilities should be granted—out of the rates, if need be—for practically all cases of typhoid fever, a large number of cases of diphtheria, and a proportion of cases of scarlet fever that need more care than their home circumstances can allow, but the money expended for this purpose can only be incidentally regarded as required for preventive medicine. The outlay would be primarily and justifiably eleemosynary, just as the outlay on our voluntary hospitals and workhouse infirmaries is at present. And if the three diseases named are thus provided for, why should severe cases of measles and whooping-cough be denied the same advantages? The answer is not obvious. Such a conception of the functions of a fever hospital differs entirely from that which

at present prevails, and without abolishing the institutions on which so much money has been spent, a Commission of Inquiry might find a method by which their up-keep might be made less burdensome to the community without essentially curtailing their usefulness to the sick poor. The general opinion of the medical profession has been seriously disturbed on the subject. Five years ago the isolation hospital was regarded as the one preventive measure on which no disagreement was possible, or even admissible. At the present moment all, or nearly all, our contemporaries have expressed their doubt as to its ability to accomplish its declared ends, and many medical officers of health have declared themselves in even more decided terms. Our own columns bear witness to the same fact. Although it is now seven weeks since we published the first of our series of papers, we have not heard from any of our readers that they are not in substantial accord with the position the writers have taken up—a sign we take to indicate that the matter is one on which they, too, would like the searchlight of inquiry turned. The question is undoubtedly one of great public moment. Delay and uncertainty are irritating, if not positively dangerous. After all that has been said and written, it is impossible to conceive tranquillity and confidence being restored until the matter has been sifted to the bottom.

#### "OUR VISITORS."

THE present week has witnessed a medico-social event of considerable interest, in that the medical men of London have been privileged to extend the hand of good-fellowship to a representative delegation of *confrères* from across the Channel. Although a friendly feeling between practitioners of the healing art has always existed, quite irrespective of the political outlook of the moment, this visit followed harmoniously in the wake of various other international functions of the kind engendered by the re-awakening of cordial sentiments between the two countries. We welcomed our French visitors the more because, in truth, we suspect that they, generally, are not as familiar with our medical and educational institutions as British practitioners are with theirs. One experiences a feeling of satisfaction at being enabled to show them that, although methods may differ, the study and the application of medical science are pursued with as much energy and perseverance here as on the Continent. For the familiarity of many English practitioners with French hospitals and schools we have to thank the unflinching courtesy with which the British medical tourist is received in Paris and elsewhere, especially if, in addition to his desire to extend his sphere of observation, there be added a working acquaintance with the French language. Our visitors cannot have failed to notice the decentralisation that characterises the organisation of our medical schools, societies, and charities, by the sturdy individualism that has achieved tolerably satisfactory results in spite of the friction and waste of energy inherent to this phase of evolution.

They will, we trust, carry away with them the conviction that the absence of State control is by no means incompatible with efficiency. It is to be apprehended that some difficulty was experienced in enabling them to grasp the fundamental difference between our general hospitals supported by voluntary contributions and the not less admirably equipped infirmaries provided by the Poor-law Service. Surprise may have merged into wonder when they learnt the immense field of clinical observation and study afforded by the latter is practically inaccessible to our medical students for reasons which assuredly will not appeal to them. The time at the disposal of our visitors was very short—only some three working days—but, judging from the programme, they were well filled, all the principal medical institutions of the Metropolis having received a share of attention. Nor was the social side neglected, for, apart from the private hospitality dispensed on a large scale by individual members of the profession to personal friends, various lunches and receptions were provided for the benefit of substantial fractions of the delegation, ending to-night in a banquet at the Hotel Cecil, at which a distinguished and numerous company of English medical men assemble to greet their foreign guests. A visit on these lines is quite a different matter from a formal international gathering such as a congress, the members whereof become mere inconspicuous items of a comprehensive scheme. It is to the congress what the *conversazione* is to the ordinary business of a medical society, and we should gladly see this mode of intercommunication developed. No profession rejoices in a freedom from mere geographical limitations at all comparable to that of medicine. Law and theology are virtually local institutions developed, at any rate in their form, in response to local requirements, but the objects of medicine as a curative art are the same in all places and in all ages. For this reason personal intercourse between medical men of different nationalities possesses an educational value not to be despised. We are all confronted by the same scientific problems and by the same material questions of professional existence, and nothing can be more useful or agreeable than to discuss these "across the walnuts and the wine."

#### KING'S COLLEGE HOSPITAL AND ANTI-VIVISECTION.

THE addresses at the opening of the winter sessions of our medical schools are the annual occasion of many oratorical effects. In many instances the speakers deal with subjects that lie outside their scientific life, and not infrequently the fruits of their philosophical ventures are more or less unripe, grotesque, and unsatisfactory. The address at King's College Hospital, London, was for the most part of the high order of intelligence, clearness, and knowledge that would naturally be associated with the eminent physician by whom it was delivered, Dr. Thomas Buzzard. One point of his address, however, as



reported in the general newspaper press, is of such an unusual character as to demand some amount of explanation by all who are concerned with the amenities of our common professional life. The statement in question may perhaps be capable of a satisfactory alternative reading, but, as it stands, it certainly suggests a popular appeal to a section of the public—the anti-vivisectionists—with whom the medical profession generally is at hopeless variance. It would be easy to imagine the glee with which the supporters of that particular cult will gloat over Dr. Buzzard's announcement. For years past, under the leadership of Mr. Stephen Coleridge, they have conducted a particularly venomous attack on the particular London hospitals in whose schools experiments on animals have been performed, or whose medical staffs have been either directly or indirectly connected with any such experimentation. Judge, then, of their feelings when they hear that the new hospital south of the Thames will be in future disconnected from the teaching school, which is to retain its old quarters in the old buildings. Further, to quote the words of Dr. Buzzard, "The laboratories of experimental pathology and also of neuro-pathology cannot conveniently be transferred to the new hospital, for the council and hospital staff are agreed that original researches in these subjects, which may involve experiments on living animals, shall find no place within its walls." This looks remarkably like a public declaration that King's College Hospital appeals to the public for support on the grounds that it is free from the taint of biological experiment. Within the last few years a small institution has come into being at Battersea, and has boldly declared itself an anti-vivisectionist hospital, but its claims and methods have not hitherto gained the approval of the medical profession. At such a time it is unfortunate that an institution of the standing and importance of King's College Hospital should make even a covert appeal to the public on a similar point. One of the present surgeons of that hospital, Mr. Watson Cheyne, and one of the past surgeons, Lord Lister, have been made the objects of particularly venomous attacks by the anti-vivisectionist party. After all, the partial severance of the two functions of teaching and of purely hospital work does not mean that experiments upon lower animals will not be performed if deemed necessary in connection with treatment of patients in the wards. It simply implies that any necessary experimental investigation will be conducted, not within the hospital walls, but in a sister building a mile or two away. We cannot possibly believe that the authorities of King's College in future intend to exclude all such investigations, which are required, for instance, to identify doubtful cases of tuberculosis, diphtheria, and certain other maladies due to the invasion of specific pathological micro-organisms. It is to be regretted, therefore, that a declaration of an ambiguous nature has been permitted to reach the public on a matter in which the interests of progressive medical science are so intimately concerned.

## Notes on Current Topics.

### Alcoholism and Insanity.

THE relationship of alcoholism to insanity is obviously one of the most important social problems that could be brought before the notice of the medical profession, especially in view of the recent steady increase of insanity in the United Kingdom. In another part of the present issue of THE MEDICAL PRESS AND CIRCULAR we print a valuable and suggestive letter upon this subject from the pen of a distinguished authority, to wit, Professor T. S. Clouston, of the Royal Edinburgh Asylum. From a study of the statistics of his own asylum he concludes that during the past twenty years there has been a steady increase in the number of cases of insanity due to alcoholism. That increase he found to be relatively greater among the rich than among the poor. Few who are acquainted with the inner life of our great cities will differ from Dr. Clouston in his conclusion that "our city and industrial population are drinking far too much for their health, and that if the present tendencies go on there is a bad look-out for the future of the people who are crowded into our cities." There can be no reasonable doubt that the drinking habits of the nation are responsible for a good deal of their madness no less than of many other of their ills. Wise and well-considered legislation in the direction of national temperance is one of the most urgently needed of all political reforms. Foreign wars and conquests may be necessary now and then, but the drink evil is ever within our walls, a burning and increasing danger.

### The Prevention of Malaria.

A STUDY of the discussion on the prophylaxis of malaria which took place at Oxford is bound to raise the question as to whether the present practice in anti-malarial operations is correct. Roughly speaking, the steps which are supposed to be necessary to rid a district of malaria consist in destroying the breeding-places of the *anopheles*. All marshes are to be drained, all ditches and pools emptied, and all water that cannot be got rid of covered with a coat of oil. It will be remembered that, some two or three years ago, in order to test the validity of these views, the Indian Government sanctioned a prolonged experiment at Mian Mir, the management of which was in the hands of officers of the Indian Medical Service. The experiment, which is now concluded, failed to produce any change in the fever returns, and its failure is held by some critics as a proof of the inefficacy of the methods we have mentioned. They are said, and doubtless truly, to be ineffectual against what may be called a compensatory immigration of mosquitoes. Further, it is claimed that, although the harmless mosquitoes may be considerably diminished in number by the activity of a "malaria brigade," there is but little evidence that *anopheles* are affected. As this work of destruction of breeding-places is very costly, and is not likely to be undertaken

unless there is a fair prospect of success, it is important to consider how far such criticisms are valid. It may be said at once that the Mian Mir experiment is insufficient both in scope and accuracy to lead to any far-reaching conclusion. Only a small area of ground was chosen, a ridiculously small sum of money was spent, and the locality was quite unsuitable as a site for the experiment, since an hour's rainfall in that district is often enough to fill pools and hollows which it had taken weeks to empty. A failure under such circumstances is in no way a set-off against the brilliant success in Ismailia, and in lesser degree in Sierra Leone, Lagos, Havana, and elsewhere. Ismailia has been practically cleared of malaria by the drainage of waste pools of water. Consequently, in certain places at any rate, the "malaria brigade" is still the strong arm of prophylaxis. But, nevertheless, it is not, we fear, universally applicable and in itself sufficient. *Anopheles* breed not only in stagnant pools, but in running water, and it is impossible to stop the irrigation of a country-side even to get rid of such a plague as malaria. In many districts reliance will have, for the present at any rate, to be placed on protection against the *anopheles* rather than on its destruction. At the same time, it would be a calamity if the Mian Mir episode were to bring into discredit a method of prophylaxis which in certain localities is not only useful but of preponderant importance.

#### "Live Rails" and Accidental Electrocution.

THE great increase in the number of electric railways throughout the country makes it a matter of public interest to consider their liability to accidents. From every part of the kingdom there come reports of serious burns, shocks, or even deaths due to accidental contact with the live rail or wire. It is noticeable that there is practically no danger in touching the live rail unless one is at the same time resting on the earth, for authorities state that there is probably no pressure of current that would do harm if one could be entirely insulated from the earth. Accidents occur commonly by the victim treading on the live rail or stumbling on it, or in some cases grasping it ignorantly in his hand. Where the overhead system is used it is obvious that an accident cannot occur so long as the wire is intact. If it breaks, however, its dangling end may cause serious results by establishing a circuit with someone standing beneath. It was formerly held that only currents of high voltage were likely to cause fatal results, but this view is now being abandoned. A brief contact with 2,000 volts may not prove fatal, whereas loss of life has resulted from contact with 250 volts, the ordinary current used for domestic lighting purposes. There is still some question as to the cause of death when a fatal result occurs, some observers maintaining that the death is due to respiratory, and others to cardiac paralysis. Even in cases of apparent death, animation can often be restored by the perform-

ance of artificial respiration. Professor Silvanus Thompson has called attention to the "live rail," which, he says, will be a thing of the past in a few years' time. There is no doubt of the danger of that system, but the alternative overhead plan is by no means devoid of risks, except, perhaps, in underground tunnels.

#### Preparation of the Surgeon's Hands.

THE problem how to treat the surgeon's hands so as to render them aseptic has not yet been quite satisfactorily solved in this country. The ordinary methods of scrubbing and of treating with antiseptics, although practically they seem to answer well, are certainly not free, in theory, from bacteriological objections. So much so that some surgeons deliberately use sterilised rubber gloves for themselves and their assistants. But these gloves are a great encumbrance, and though custom enables a surgeon to gain a certain amount of dexterity in them, he can never have the same skill when using them in delicate manipulations as he enjoys with the bare hand. An ingenious method has been devised by Dr. John B. Murphy, of Chicago, and it has given such excellent results in his practice, and seems so free from objection, that it may well be given a trial over here. The plan he adopts is to use a solution of rubber dissolved in benzoin solution as a pigment for the hands, and when this is painted over and allowed to set an impermeable coating is formed which neither allows the wound to be contaminated by secretions from the hands of the surgeon, nor the hands to be infected with purulent or other discharges from the patient. Dr. Murphy uses a similar solution in which acetone is the solvent for application to the patient's skin in the neighbourhood of the wound, and he is so well satisfied with both measures that he now employs them in all cases. The idea strikes us as a good one, and if it is as serviceable in practice as it sounds in theory the solution should prove a god-send to surgeons who suffer from cracked hands and horny fingers.

#### Medical "Frumps."

IF "manners makyth the man," no less surely does dress make the woman, and whether from a desire to dissociate themselves from the fashionable world, or from a determination to carry their ideas of the hygienic requirements of dress into practical operation, the early medical women certainly brought down a good deal of ridicule upon themselves by their mode of attire. Tactically this was a mistake. Clean, fresh-looking girls with neat figures and pretty costumes would have won their battle far more easily than dowdy women with sad colours and weirdly grotesque dresses. Moreover, impressions once created take long to efface. The male medical student to the public is still the rowdy, beer-drinking creature that Bob Sawyer was, and female medical students are likely to be "new" women in the eyes of the world for many a day. Miss Murdoch, in her introductory address at the School of Medicine for Women, deplored the fact that the stigma

of carelessness in dress still rested upon the woman-doctor, and urged her audience to do their best to remove it. In her view the female "medical" should be of the world as well as in it, and it will surely not need much insistence to oblige the sweet girl-graduates "not to lose touch with theatre or music; to go to parties; to go out into the world and exchange ideas with others." But there is another possibility to be faced. If the lady student dons the costume of the age and mingles freely with the giddy world there is considerable danger that she may soon find herself the subject of a *vivâ voce* examination requiring an affirmative, monosyllabic answer. And if this be given, what sort of future will there be for female medical education?

#### Wooden Heads and Wooden Legs.

THE enthusiastic "first-aider" has been the subject of a good deal of chaff in the past, but he has certainly come to stay. Still, he wants a little improvement. We pointed out recently that, admirable as much of the work of the St. John Ambulance Association is, the courses of instruction are far too short, and that though the treatment of injuries is well taught, the diagnosis of those injuries is inadequately dealt with. An accident reported near Victoria Station the other day—if true—illustrates this defect in a rather amusing manner. A Mr. Thomas, from New Brompton, arrived on a visit to the Metropolis, but either through want of acquaintance with the danger of London streets or lack of the necessary agility, he had the misfortune to be knocked down by a hansom. The usual crowd collected, and, on finding the subject of its attention unable to rise, diagnosed a fracture of the leg. A handy police constable arrived opportunely on the scene, and took the case in charge. Demanding materials for a splint, he was provided with a broom-stick, and, with the aid of a workman's saw and some readily proffered handkerchiefs he quickly manufactured a capital substitute for a "long Liston." The crowd gaped with wonder, at the ingenious constable, and murmurs of admiration arose at his promptitude and dexterity. But, alas! for human fallibility, the preparations, like those made by the town rat for his guest from the country, were doomed to futility through unexpected circumstances. While the constable worked and the crowd gaped the patient sat up, rubbed himself, and sprang on to the sound foot. Before the bystanders could recover from their astonishment and indignation the patient was nonchalantly marching up the street, gaily swinging the injured leg; it was a wooden one. It is fair to add that by another and later account a makeshift wooden leg was made out of a broom-handle by the skill and readiness of the station constable.

#### Long Hours and Nerve Strain.

THE physiology of fatigue is full of practical importance to all who lead the strenuous life, whether it be of the body or of the mind, for it is

well to be aware of the means by which nervous energy may be economised and exhaustion of the tissues staved off. It will be generally admitted that the best work is nearly always done by severe concentration of the mental powers continued for a considerable period of time. The amount of work that can be got through by steady application for a long stretch of time is surprising, though when the end is accomplished and there is nothing left to work for, reaction quickly takes place and at the end of the day the feeling of which the worker is most conscious is vexation of spirit. This applies more particularly, of course, to mental work, for mere animal fatigue resulting from hard physical toil is somewhat easier to bear. The very act of sinking into an arm-chair when one is bodily tired is in itself a pleasure, and if the mind has been comparatively unoccupied new delights are experienced in music or in an interesting book. The responsibility attached to certain higher forms of work is, in nine cases out of ten, more wearying than the performance of the actual duties themselves. Some types of mind are totally unfitted to hold responsible posts; the mere knowledge that others will be influenced by their every act, either for good or evil, would be almost enough to drive them out of their senses. Such are destined to work under the direction of others all their lives. However well balanced a mind may be, there is a limit to its working capacity, and if this limit be exceeded a breakdown must occur sooner or later. The report of the Board of Trade upon the recent collision at a North London terminus very wisely laid stress upon the hours of duty worked by a trusted signalman as being far too long for the heavy and responsible nature of the work. It is a wonder, indeed, that cases of "error of judgment" do not happen more frequently, especially if railway companies will persist in economising at the expense of servants who are continually subjected to a high degree of nervous strain.

#### Boric Acid and Kidney Disease.

MUCH has been written of late about the effects of boric acid and borax upon the body when these substances are consumed in the form of food-preservatives. As far as the stomach is concerned, it would appear that fairly large quantities of boric acid may be ingested without producing any ill effects, for as much as forty-six grains have been taken fasting without any discomfort or untoward symptoms. Some observers have found that the drug acts as a mild aperient, even when taken in the small proportion employed to preserve milk. Other foods, such as corned beef, have been known to contain as much as 3.87 per cent. of boric acid, a point of some importance in view of the fact that among certain classes of the community this is a common form of meat-consumption. It is yet debatable as to whether the borated foods endanger the public health. Fere has shown, however, that the repeated use of boric acid or borax may be accompanied by a decided risk of producing or aggravating lesions of the kidneys.

Albuminuria not infrequently follows their internal administration. Professor Charles Harrington, (a) of Harvard, has recently conducted a series of experiments in order to ascertain if the kidneys are commonly affected by a continuous diet of food preserved with boric acid. Twelve healthy male cats were selected and were placed exactly under the same conditions. Six of them received daily, for a period of nineteen weeks, varying amounts of borax. One of these animals died quite early, but the others were killed at the end of the appointed time. Of those which had received the preservative five were found, post-mortem, to be suffering from lesions of the kidneys analogous to those of subacute and chronic nephritis in man, microscopical examination of sections of the organs showing the presence of interstitial infiltration of the cortex. In view of these facts some caution is needed before we can state absolutely that boric acid is devoid of injurious effects.

#### Hygiene in the East.

HYGIENE as a science being in these countries the most modern of all, we are accustomed to regard it as if it were equally new the world over. As a matter of fact it is one of the most ancient, and from time immemorial the races of the East have practised its maxims with exactitude. We noticed in a recent medical address a casual reference to the Japanese as probably the most highly civilised race the world has ever seen, and, although the statement may somewhat stagger assent, yet, if cleanliness be the standard chosen their pre-eminence may be granted. It is doubtless due quite as much to a wish for immediate comfort as to a larger view of health that dwellers in warm climates devote so much more time to personal hygiene than is dreamt of by the populace in colder zones; but whatever be the origin of the greater cleanliness of the tropics it is interesting to note the detailed attention that has been given to it by prophets and lawgivers. Through the Old Testament we are all familiar with the elaborate ritual of hygiene which was imposed upon the Jews, though, indeed, in their migration to other climates it tends to become little less than ritual, and to lose much of its living spirit. Some of the Jewish customs, however, still universal, among them, are well founded in the laws of health, and much of the virility of that wonderful people is doubtless due to their continued observance. Such, for instance, are the practice of circumcision, and the custom of marital abstinence for a definite period after menstruation. Of great importance, too, is the rigid attention given to examination of meat intended for food, disease in any part being sufficient to condemn the entire carcass. In the chapter on water in Avicenna's work, written in the eleventh century, and probably summarising the Arab wisdom of his day, the clearest directions are given to aid one in judging good from bad water, and

boiling is recommended in all cases of doubt or suspicion. He writes sensibly of the therapeutics of pure water, and he warns against its conveyance in leaden pipes as productive of bowel complaints. It is interesting to note, too, a saying attributed to Mahomet, and well borne out by modern discovery: "If a fly fall into a drinking water-vessel, that vessel must be washed, for a fly carries disease in one of its wings."

#### Human Foot-and-Mouth Disease.

ON various occasions during epidemics of the dread disease of cattle known as "foot-and-mouth disease," infection of man has taken place. The disease is marked by vesicles and ulcers on the mucous membrane of the mouth, and when men have been attacked the disease usually has run an acute and fatal course. Apart, however, from any known connection with foot-and-mouth disease, but occurring principally among butchers, several cases of acute pemphigus of remarkable type have been noted. There was usually a severe infectious dermatitis with hæmorrhagic bullæ, having a special tendency to affect the mouth, palate, and nostrils. The course was rapid and fatal. In Boston, in 1902, following on the use of infected vaccine lymph, a series of ten cases of this type of infective dermatitis appeared, while, curiously enough, in Wakefield, in 1903, an epidemic of foot-and-mouth disease originated with the inoculation of a calf with impure virus. Though the fact that the infection in each case can be conveyed by vaccine lymph is not sufficient to establish the identity of the two diseases, yet it will be seen that there are sufficient grounds for suspecting that infectious pemphigus in man and foot-and-mouth disease in cattle are closely allied.

#### Work as a Therapeutic Measure.

AN American contemporary in a recent issue devotes an editorial article to the discussion of work as a rational method of treatment, and thinks that in recent years its efficacy has been somewhat overlooked. The importance of rest is recognised, not merely by every practitioner of medicine but, at any rate in the abstract, by nearly every patient, and elaborate systems of treatment, such as Dr. Weir-Mitchell's, based thereon have been demonstrated to be of value. On the other hand, while we often advise physical exercise as a therapeutic measure, we but rarely advise work pure and simple, and there has been no attempt to systematise a method of treatment which should have work, either physical or mental, as its fundamental principle. While there are doubtless many cases drifting into invalidism where regular and ordered work is the only restorative needed, yet we think that more often regulation of the hours and methods of working is what is required. It is rare enough to meet with anyone suffering from sheer overwork, though common to find patients broken down under uncongenial toil, and ill-regulated hours of labour, and it is in cases like these that the careful advice of the physician

(a) *Amer. Journ. Med. Sci.*, September, 1904.

may be most useful. With those suffering from sheer idleness, however, we do not think much good is likely to result from the prescription of work, unless some scheme could be devised for carrying it into effect with the same rigour as is done in the case of rest by Dr. Weir Mitchell.

#### Eye Massage.

THE anti-vivisectionists have, by their methods, unfortunately alienated the sympathy of most right thinking people, and with every desire to be fair, it is nevertheless impossible, after what has taken place in the past, to have any dealings with them now. Under the leadership of Mr. Stephen Coleridge, they have practically declared war to the knife with the medical profession, and they have carried on their campaign by the most disingenuous methods. Perhaps their latest move, the establishment of an "anti-vivisection" hospital, is the most deliberately mischievous of any of their performances, for it invites the suggestion that "vivisection" is carried on as a part of the general practice of other hospitals. No sane man can believe that they will fail to avail themselves of knowledge that has been gained by experiments on animals; indeed, it would be impossible for them not to do so. Inoculation, moreover, as a means of diagnosis, is a daily necessity in hospitals where scientific medicine is practised. Unhappily, the anti-vivisectionists have found it possible to obtain a medical staff. In the case of the eye department, they have secured the services of a Mr. Stephen Smith, who has recently set at naught the recognised usage of the profession. Having "discovered" a method of correcting defects of vision by manipulation of the eye-ball, instead of availing himself of the usual channels for submitting his method to the expert judgment of the profession, he has seen fit to describe it to a general gathering of press reporters. He is now engaged in an unedifying duel detailed at some length in the *Daily Mail*, and has nominated as his "referee" a Dr. Ettles, of the Minorities. We do not think either of these gentlemen is likely to raise himself in the estimation of his colleagues by his action, and both of them may easily do the reverse.

#### Our French Visitors.

OUR visitors are having a busy time. After the reception at the Hotel Russell on Sunday evening, at which many eminent members of the profession in London were present, the serious business began on Monday morning with a visit to the Royal College of Surgeons of England, where the visitors were received by the President in his robes, supported by members of Council. The President welcomed them to the College in French, and invited them to visit the scene of John Hunter's triumphs. Great was the admiration excited by the inspection of the museum, its extent, its symmetry, and the inimitable care with which the collection is maintained and cared for. General regret was expressed at the inadequacy of the time at the disposal of the visitors to take cognisance of the multitudinous objects of interest.

Then followed a complimentary lunch offered by the editor of the *Lancet* at the Imperial Restaurant, which was presided over by Mr. Thos. Wakley, Junr. A letter was read from Mr. Wakley, Sen., who, though prevented from being present by his advanced years, welcomed his French conferees to England and expressed the hope that if they did not add much to their medical knowledge, they would, at any rate, carry away a souvenir of the sympathy and affection which English practitioners felt for their French brethren, and he referred in touching terms to his own experience of French hospitals in days long since. Due praise was accorded by representative members of the French medical profession to the importance of the *Lancet* as an organ of professional interests. The next item was a visit to St. Bartholomew's Hospital, where the visitors were received by the members of the staff and conducted in sections through the wards and laboratories. The home-like comfort of the wards and the ample floor space accorded to each patient were much admired, and after having completed the inspection of the hospital the visitors were taken to the palatial board-room, where the portrait of Henry VIII. attracted special attention. A visit to this famous institution would obviously not be complete without a pilgrimage to that interesting old structure, the Church of St. Bartholomew, the history of which was duly narrated by the vicar and translated into French for the benefit of those who did not understand English. After dinner the visitors adjourned in large numbers to the magnificent reception organised by Dr. and Mrs. Dundas Grant at their residence in Cavendish Square, where sweet strains were dispensed at intervals by Mr. Edouard Crosse's orchestra. Mr. Walter Kirby, the Australian tenor, elicited warm applause by his rendering of several choice songs. Metropolitan practitioners were largely represented at this gathering, and the greatest animation prevailed throughout in spite of the apparently slight obstacle due to the difference of language.

#### PERSONAL.

ON Saturday last, October 8th, H.R.H. the Duchess of Albany formally opened the new operating theatre of the London National Hospital for the Paralysed and Epileptic in Queen's Square. After the ceremony the Duchess inspected the hospital.

AN address was presented to the Duchess by the Chairman of the Board, Mr. John Dundas Power, and later Sir Victor Horsley announced a gift of £1,000 to endow a table in the department of nervous diseases research.

IT transpires that the medical man who rendered such splendid service in the recent railway disaster at Llanelly was Dr. Hepburn, the well-known Professor of Anatomy in Cardiff University College.

IN one account of the accident it is stated that invaluable assistance was rendered to the injured by Mr. Harry Watkins, of Brixton Lane, London, who was travelling in the train, and who was happily unhurt.

WE regret to say that the name of Dr. W. P. Jones, of Sheffield, appears among the injured, with an

intimation that there is a fracture of the pelvis, but, happily, an early recovery is expected.

MR. FREDERICK RANSOM, a well-known citizen of Ipswich, has endowed a bed in the East Suffolk and Ipswich Hospital at a cost of £1,000.

THE annual distribution of prizes in connection with the Welsh Border Brigade Bearer Company was made by Colonel A. W. Duke, M.D., R.A.M.C., Principal Medical Officer N.W. District.

THE KING, on the recommendation of the Home Secretary, has added the name of Dr. Donkin, one of his Majesty's Commissioners of Prisons, to the Royal Commission appointed to inquire into the care of the feeble-minded.

A PRESENTATION was last week made to Dr. Albert Bradshaw, of Wattlesborough, Montgomeryshire, by friends and patients, on the occasion of his leaving the district to practise in Birmingham.

THE *Times* has announced the approaching marriage of Mr. T. Mark Hovell with the Hon. Margaret Cecilia Bateman-Hanbury, daughter of the late Lord Bateman, and sister of the present peer.

DR. J. F. J. SYKES, Medical Officer of Health for the Metropolitan District of St. Pancras, will deliver the Presidential Address of the Incorporated Society of Medical Officers of Health at 9, Adelphi Terrace, London, on October 14th next, at 5 p.m. The annual dinner of the society will be held at the Trocadero Restaurant in the evening of the same day.

LORD LUDLOW has been appointed a member of the weekly board of the Middlesex Hospital.

SIR ALFRED FRIPP, owing to the pressure of engagements, has resigned his position as a member of the Advisory Board for Army Medical Service. Sir Alfred has been a member of the Board since it was established three years ago.

THE rumour is contradicted that Sir Frederick Treves is to succeed to the office recently vacated by Sir Wm. Taylor, K.C.B., Director-General of the Army Medical Service.

SIR ISAMBARD OWEN, who has been appointed principal of the Durham College of Science, and is well known in the medical world as a professor of St. George's Medical School, has rendered excellent service to the cause of higher education in Wales. A Welshman by birth, he was some years ago appointed Deputy-Chancellor of the University of Wales.

It is announced that Dr. Blachford has been appointed medical superintendent of the Bristol City Lunatic Asylum, at Stapleton, to fill the vacancy occasioned by the recent death of Dr. Benham.

DR. MACLAREN, who has held the post of senior surgeon at the Cumberland Infirmary, at Carlisle, for upwards of thirty years, has resigned that appointment, and Dr. Lidiard, Carlisle, now becomes the senior surgeon at the institution.

SIR DYCE DUCKWORTH has been appointed to the vacancy in the offices of Medical Referee to the Treasury, and Medical Adviser to the Pensions Commutation Board, caused by the resignation of Dr. Lionel Beale, F.R.S.

THE first general meeting of the Medical Society of London will be held on Monday, October 10th, at 8 p.m., and the first ordinary meeting at 8.30 p.m. on the same day, when the President, Mr. John Langton, will deliver the opening address.

THE office of Principal of the Durham University College of Science at Newcastle-on-Tyne was rendered vacant by the death of Dr. H. P. Gurney, who was killed while mountaineering in Switzerland in August.

DR. G. A. GIBSON, of Edinburgh, will open the Winter Course of Post-Graduate Lectures in connection with the Mount Vernon Hospital, at the Central Out-Patient Department, 7, Fitzroy Square, London, with an address on "Certain Aspects of Pleurisy."

DR. ERNEST W. WHITE, for many years Medical Superintendent of the City of London Asylum at Dartford, has been granted a superannuation allowance of £1,000 per annum.

## Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

### SCOTLAND.

QUEEN ALEXANDRA SANATORIUM, DAVOS.—Lord Balfour of Burleigh, Chairman of the Committee for the Sanatorium, addressed the first of a series of meetings to be held in the larger Scottish towns on behalf of this institution in Glasgow, on the 5th inst. The scheme is to build a thoroughly up-to-date sanatorium, of about one hundred beds, for the benefit of patients able to pay 25s. or 30s. a week. The committee require about £50,000 for a start, and of this they have already got upwards of £6,000. The British nation was the first in Davos to have an institution of this kind at all, but others have now outstripped us, and it is hoped that the new sanatorium, in which patients can be treated for the bare cost of maintenance, will bring us level in the race again.

MURRAY'S ROYAL ASYLUM, PERTH.—The new villas for male and female patients were opened, and the new chapel dedicated on the 29th ult. Among those present were Lord Mansfield, Sir James Crichton Browne, Provost Love, Perth, and others. Murray's Asylum, opened in 1827, is one of the seven Royal asylums in Scotland. It has recently been modernised, and several new villas have been erected at a cost of over £2,000 each. The chapel has been subscribed for by patients and friends of the institution, and was erected from plans prepared by Dr. Urquhart, the medical superintendent of asylum. After the luncheon which followed the ceremony, Sir James Crichton Browne proposed the toast of the Murray Royal Asylum in a graceful speech, in which the modern treatment of the insane was contrasted with that of the old days, in which madness was regarded as demoniacal possession and sufferers from it, if not cured by exorcism, as deserving of being treated like wild beasts, starved, bound, beaten, done to death, or caged in noisome cells where they were littered on straw, exposed to cold and hunger and to nameless barbarities by their keepers, and sometimes exhibited to gratify public curiosity.

CHALMERS' HOSPITAL, EDINBURGH.—This hospital will soon be again ready for the admission of patients, it having been closed since July pending the building of a new operating theatre, the installation of special baths, and the adaptation of part of the grounds to open air treatment. The hospital owes its existence to George Chalmers, a plumber in Edinburgh, who died in 1836, bequeathing the greater part of his fortune for the erection of a hospital for the sick and hurt. The funds were entrusted to the Dean and Faculty of Advocates, who wisely allowed them to accumulate until 1861, when the building, opened in 1864, was commenced. In accordance with the desire of the testator, the wards have been divided into public or free wards, and private wards. The latter are the chief claim which the hospital has to fuller support, for they afford a means of obtaining hospital treatment to those who, too well-to-do to accept of charity, are yet unable to pay the charges of a private nursing home. During 1903, 195 patients were treated in the public and 113 in the private wards, while 2,578 out-patients were



dealt with in the waiting-room. Dr. Muirhead is physician to the hospital, and Mr. H. J. Stiles succeeds Sir P. H. Watson in the post of surgeon.

#### BELFAST.

THE MEMORIAL TO DR. McKEOWN.—A circular letter has been issued by the committee in charge of the proposed memorial to Dr. McKeown, showing that subscriptions amounting to about £100 have been received, and asking for further subscriptions. The appeal is grounded chiefly on Dr. McKeown's work as a patriotic citizen interested in educational concerns. After detailing some of the affairs in which he interested himself, the letter proceeds:—"It is not intended that a memorial should be taken as an indorsement of all the views and all the efforts of Dr. McKeown, but as a public recognition of the very honest work of a great, truthful Irishman, who had high ideals. Dr. McKeown conceived that the relations between the State and the citizen should have the same openness, and should be marked by the same absence of underhand dealing, and of all forms of wire-pulling and back-door influence, as should mark the relations of honest friends in private life and the transactions of honest men in commerce. Whether or not his criticisms of individuals or organisations or of their methods were always accurate, it is recognised that he was in all things single-minded and steadfast, and that he spoke the truth as he thought it in his heart." These sentences indicate precisely where Dr. McKeown's weakness lay, and explain why he accomplished so little in educational affairs. Trickery and wire-pulling were perfect bogeys to him, and he saw them in every action of those who opposed him. He was of the stuff that martyrs are made of, not business men. The form which the memorial will take has not yet been decided, but it is intended that it shall be one in harmony with Dr. McKeown's public services.

THE FORSTER GREEN HOSPITAL FOR CONSUMPTION AND THE CORPORATION.—At a meeting of the city Corporation last week it was reported that the Lord Mayor and several members of the Corporation had met with the authorities of the Forster Green Hospital at a private conference, and afterwards had waited on the Local Government Board to discuss ways and means for the establishment and maintenance of a Sanatorium for consumptives. It is clear from this that there is some truth in the reports that have been circulated, that the Corporation is considering the possibility of taking over and enlarging the Forster Green Hospital, instead of building a new one for the city.

### Correspondence.

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

#### ALCOHOLISM AND INSANITY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I entirely agree with your remarks in your issue of this date (October 5th) as to the difficulty and fallacy of attempting to assign with definiteness all the causes of any case of mental disease. But in most cases we can by careful inquiry ascertain the chief immediate or exciting cause of an attack. No doubt in very many instances the patient's brain had been in so unstable a state that a very slight cause indeed would be sufficient to produce the final and marked mental upset for which the patient had to be placed under treatment in a mental hospital. When alcohol becomes a chief etiological factor of insanity I think it is very important from a social point of view that special attention should be directed to the fact, because it is to a large extent a preventable cause. We all know that unstable and hereditarily weak brains are those that are most liable to the alcohol craving, and when poisoned by excess of the stimulant they are specially apt to be upset in their mental working. I think that such persons should all be made to know the risk they run from alcohol. In fact,

those risks should be made a part of their school education, and the duty of avoiding them be instilled into their consciences. At present many persons sin in this way through ignorance. Hence I and others, notably Dr. Conolly Norman, of Dublin, Dr. Parker and Dr. Marr, of the great Glasgow asylums, who see much of alcoholic insanity, look on it as a duty to accentuate the facts in our reports and spread as widely as we can our inferences from these facts. As you well know, the effects of alcohol on the brain are far more accurately observed now than they were some years ago, and we can speak, therefore, with more dogmatism and authority on the point.

Now, when we find that alcoholic insanity is increasing in our institutions, that it is in the city asylums where that increase is most seen, and that within a few years past the figures are really alarming, I think you will agree with me that we should fail in our duty if we did not draw the attention of our profession and the public to the matter by every means in our power.

As to the statistics of the Royal Edinburgh Asylum in regard to alcoholic causation of mental disease, they are very striking. As is well known to the profession, alcohol may act as a cause of an attack of ordinary insanity, or it may produce a true "alcoholic insanity," accompanied by characteristic symptoms such as vivid hallucinations, pareses, neuritis, &c. I find that 40 per cent. has to be taken off the whole number of cases in which the alcohol has been a distinct exciting or predisposing factor to get the number of cases of true alcoholic insanity. Treating our statistics in this way, so as to put them on a scientific basis and to eliminate error, I find that for the ten years 1874-83, 12 per cent. of the admissions of both sexes were cases of alcoholic insanity; that for 1884-93 they amounted to 13 per cent.; for 1894-1903, 17.5 per cent.; and for 1903, 23 per cent. The gross alcoholic percentage of 42.3 for the men for 1903, to which you refer, reduced to 28 per cent. of true alcoholic insanity, perhaps represents an exceptional year, but it is a fact, and is on the whole on all fours with the Dublin and Glasgow statistics for 1903. The gross alcoholic percentage in the male admissions of the two great Glasgow asylums at Gartloch and Woodilee for 1903, was 33.9 per cent. of the admissions. The last English Blue Book shows that for the whole of England and Wales the male pauper admissions showed an alcoholic percentage of 23.7 for the past five years, this including the country asylums, as well as those of the large cities. In the rural and non-manufacturing districts, the percentage is not nearly as great as this, leaving a much larger amount for the cities. In the Montrose Asylum, accommodating the rural part of Forfarshire, the percentage for both sexes for 1903 was only 8. The last Irish Blue Book showed for 1903 a percentage of 10.5.

Our statistics of general paralysis for the past thirty years confirm the general inference that drink and syphilis, for they go together largely in this country, are increasing in our cities. It has risen from 6 to 13 per cent. in that time.

Our statistics and those of the English Lunacy Blue Books—the Scottish Blue Books do not as yet give complete etiological statistics of the admissions to asylums—seem to show that neither alcoholic insanity nor general paralysis are as common in the private class of patients as among the rate-paid. In our Craig House department for the more wealthy private patients we had only 9 per cent. of alcoholic admissions for 1903. In England the private class for the five years 1898-1902 showed only 12.9 per cent. of alcoholic causation for both sexes, against 16.35 among the paupers.

I am well aware that "figures may be made to prove anything," and that we have as yet no exhaustive statistical inquiry to throw light on this grave social question. But I contend the figures I have quoted do make out a strong *prima facie* case for the conclusion that our city and industrial populations are drinking far too much for their brain health, that their brain resistiveness against the

evil effects of alcohol is lessening, and that if the present tendencies go on there is a bad look-out for the future of the people who are crowding into our cities, and who, in spite of improved sanitation and a lessened death-rate, do not seem to be acquiring the self-control especially needed to resist the temptations and dangers of an urban life. There is no single agent that can do their mental condition so much harm in the circumstances in which they are placed as excess of alcohol, and none that will affect their progeny so badly in mind and body. The process of acclimatisation of a man or woman bred in the country to a city life and environments is a dangerous one; certain bad results show themselves at once, while others take years to do so. Alcoholic insanity seems to be one of the latter kind.

I am, Sir, yours truly,

T. S. CLOUSTON, M.D.

The Royal Edinburgh Asylum,  
October 5th, 1904.

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Whatever bearing upon this question Dr. Woods Hutchinson's article (referred to by a correspondent in THE MEDICAL PRESS AND CIRCULAR of this week) may possibly have is not apparent in the quotations cited. All living creatures lower in the scale than man are controlled by natural forces against which they do not contend by action based upon knowledge and reason. Civilised mankind alone have obtained the power to mould as they please their physical and moral development. The type of future man which shall predominate is capable of production with as much certainty as the breeder of horses, cattle or dogs can produce in time creatures of the type adapted best to his purposes. Creatures below the level of man do not sin, they have no vices; men are sinners, vast masses of them are full of vice or are at best permeated by a narrow selfishness, by an egoism which subordinates every consideration to the desire for a life of ease and "pleasure" for themselves and those they love. "Let us eat, drink, and be merry, for to-morrow we die." "What has posterity done for us that we should sacrifice for posterity?" These sayings express the sentiments of decadent civilisations. If such ideas triumph as they are doing in France and seem likely to do throughout the other races of modern European origin, the doom of these nations is sealed. The Yellow Peril may in time become a reality, and if after the lapse of a few centuries Macaulay's New Zealander be not found contemplating the ruins of London from a broken arch of the bridge, the glory of the Empire may none the less have departed, and the world's dominion fallen from the hands of the Anglo-Saxon into those of a more vigorous and wise, albeit, perhaps, an Asiatic people.

I am, Sir, yours truly.

A STUDENT OF SOCIOLOGY.

October 5th, 1904.

#### WHOOPING COUGH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In an article on the "Bacteriology of Pertussis" (October 5th, 1904), I find the following: "Moreover, for generations it has been recognised as infectious, and no observation has thrown any doubt on this belief." May I correct this statement in the briefest manner. When I joined the Hospital for Sick Children in Great Ormond Street it was the opinion of the majority of the staff that whooping-cough was a nervous disease, and the view of Dr. Niemeyer was entertained by many. In a letter to the *Lancet*, January 3rd, 1898, I mentioned how Sir Thomas Watson had changed his views of the disease, and in a paper read before the Medical Society and published in Vol. V. of its *Transactions*, I endeavoured to show how Cullen was wrong in classifying whooping-cough along with asthma as a spasmodic disease. I remember well meeting my old friend the late Dr. Sturges one day in St. James's Park, when he said he was coming round to my view that

whooping-cough was infectious. Dr. Niemeyer's view that a birch-rod was a good remedy will give some idea of German pathology. I am rather amused to find articles in our medical journals winding up with some such name as Manicatide, or Czaplewski, and I hope that THE MEDICAL PRESS AND CIRCULAR will keep clear of this curious weakness.

I am, Sir, yours truly,

ROBERT LEE.

October 7th, 1904.

[We thank Dr. Lee for calling attention to this fact. There is no doubt that the "birch-rod" standpoint was the accepted one some twenty or thirty years ago. Dr. Lee first insisted on the infectious nature of whooping-cough. His conclusion was based on clinical grounds, and a study of 3,000 cases. An interesting account of his researches will be found in the *Lancet* January 3rd, 1898.—ED.]

#### Obituary.

EDWIN HAWORTH, M.B., C.M.Glasg.

WE regret to announce the death of Dr. Haworth, M.B., C.M., medical officer of health for Oswaldtwistle, near Accrington, Lancashire, in his fiftieth year. He leaves a widow and three young children. He was educated medically at the University of Glasgow, where, in 1879, he graduated M.B. and C.M.

DAVID ROBERT JONES, L.R.C.P.Ed., L.M.

MR. DAVID ROBERT JONES, one of the best-known public men in North Wales, died at his residence, Corwen, on September 30th. For upwards of a quarter of a century he had been chairman of the Corwen Board of Guardians. He was a native of Bala, was justice of the peace for Merioneth, a member of the governing body of Bala County School, and held many other public offices. He was a prominent Churchman, and leader of the local Conservative party. His medical education was conducted in Dublin, whence in 1870 he took the qualification of L.R.C.P.Edin. and L.M.

HAMILTON HODGES, L.R.C.P.Edin., &c.

THE death is announced of Dr. Thomas Hamilton Hodges, for fifteen years parish doctor at Killin, and latterly of Yetholm and Tweedsmuir. Dr. Hodges was born at Stair in 1849, and received his medical education at Glasgow, in which city he commenced practice before removing to Killin, where he formed one of the most extensive practices in Perthshire. He was a J.P. for Perthshire. Dr. Hodges retired to Tweedsmuir about three years ago, a paralytic seizure having obliged him to practically relinquish all medical work. He took the qualifications of L.R.C.P.Edin. and L.F.P.S.Glasg. in 1873.

#### Literary Notes and Gossip.

THE *British Journal of Children's Diseases*. (Edited by George Carpenter, M.D. No. 9. Vol. i. September, 1904.)—This journal contains:—(1) A case of hydrocephalus, in which drainage of the ventricles into the subdural space was established, by C. A. Morton, F.R.C.S. In spite of the establishment of a drain on both sides of the brain, the cerebro-spinal fluid continued to collect, and the child ultimately died. (2) A case of congenital stricture of the oesophagus, by Bertram M. H. Rogers, M.D. The stricture was situated about an inch from the lower end of the oesophagus, but no account is given of its tightness nor of the structure of its walls. (3) Some of the less commonly recognised manifestations of rheumatism in childhood, by James Burnet, M.A., M.B. Among the more important of these manifestations Dr. Burnet includes tonsillitis, pharyngitis, pneumonia, psoriasis and appendicitis. Most of these conditions, he states, are benefited by salicylates. (4) On night terrors and sleep-walking, by the Rev. Arthur L. Hussey, M.A. (5) An editorial on "Delayed Chloroform Poisoning."

THE *Boston Medical and Surgical Journal*, (Vol. cli. No. 8. August, 1904.)—Two papers on hydrotherapeutic measures appear in this journal. In both of them the advantages of this method of treatment is pointed out, and in one of them, the fact is referred to that both in England and America the subject has been neglected. That, however, there are signs of the advance of this and other physical methods of treatment is plain from recent publications. Dr. E. W. Taylor, of Boston, contributes an interesting study of a case of sacral spina bifida. Anæsthesia was present over a portion of the gluteal region and over the lower part of both legs in this case. This anæsthetic area corresponded closely with the area marked out by Thortum and Head as being supplied by the sacral nerves, and differed considerably from the sacral nerve area, as described by Starr and by Kocher. The appointment of Dr. Osler to the Chair of Medicine in Oxford is referred to by the Editor. While expressing regret for his loss, the writer says that "the entire medical profession in America may well feel a certain pride in this choice for the Regius Professorship at Oxford."

*American Medicine*. (Vol. viii., No. 9. August, 1904.)—The subjects dealt with in this journal are very numerous. Among the reports of clinical cases the most interesting is "A case of fibro-myxosarcoma of the sacrum of large size successfully treated by cataphoric operations, with preservation of the sphincter," by G. B. Massey, M.D. An incision was made immediately posterior to the anus, and through this, an electrode was passed up towards the tumour, and a current as high as 1,600 milliamperes was then allowed to flow for three hours. Two applications resulted in the sloughing away of the entire tumour, together with the coccyx. The wound cicatrised, and the patient recovered. Among the "Original Articles" is a paper by Collin F. Martin, on the "injection treatment of internal hæmorrhoids." His technique, for which he claims very successful results, consists in (1) Stretching the external sphincter under nitrous oxide anaesthesia; (2) after an interval of from four to seven days a conical speculum is inserted. Into this the hæmorrhoid prolapses when the patient coughs; (3) the hæmorrhoid is washed and injected with about 7 m. of a carbolic acid solution; (4) an ichthyol suppository is then inserted. A paper on "The beneficent agency of peritoneal exudates, adhesions, aperistalsis and meteorism in peritonitis" is contributed by H. C. Wetherill, M.D. Although there may be some small grain of truth in his contentions, few practical physicians will, we fancy, agree with most of his reasoning.

*New York Medical Journal and Philadelphia Medical Journal*. (Vol. lxxx., No. 8. August, 1904.)—The Original Communications in this number include:—(1) "The management of genital sores," by E. Wood Ruggles, M.D. (2) "The best method of operation to effect a radical cure of senile hypertrophy of the prostate gland: based on the study of 150 radical operations." The author, Dr. Orville Horvitz, comes to the following among other conclusions:—(i) There is no routine treatment for prostatic enlargement. (ii) The dangers of catheterism are greater than those of a radical operation, performed early. (iii) The proper time to perform a radical operation is when daily catheterism becomes necessary. (iv) In 90 per cent. of cases the gland can be removed from the perinæum. The perineal operation of Bryson is considered the operation of choice. (v) If the bladder be hopelessly disabled the results of operation are negative. (3) "The Finsen light treatment," by R. H. Stevens, M.D. The importance of securing a properly made lamp is insisted on. (4) "The etiology and treatment of arterio-sclerosis," by O. T. Osborne, M.D. (5) "Talma's operation for cirrhosis of the liver," by L. B. McBrayn, M.D. (6) "Renal insufficiency," by Antonio M. Crispin, M.D. In this paper, the author refers to the importance of making frequent

estimations of the total urinary solids excreted, in diseases of the heart and other organs. (7) "Surgery under difficulty in East Africa," by Samuel Gurney, M.D.

## Medical News.

### The Society for the Study of Inebriety.

AT the Quarterly Meeting of the above Society held on Tuesday afternoon, October 11th, HARRY CAMPBELL, M.D., F.R.C.P., President, being in the Chair, at the Rooms of the Medical Society of London, Dr. CHARLES F. HARFORD delivered an address, entitled "The Drinking Habits of Uncivilised and Semi-civilised Races," which will be found under the heading of "Original Communications," page 380.

### Jervis Street Hospital, Dublin.

THE Governors and Guardians of Jervis Street Hospital, Dublin, will meet on Monday, the 17th inst., to appoint a surgeon in succession to the late Dr. Cranny, and a physician in succession to Dr. Martin, who has resigned his post as announced in our last issue.

### St. Mary's Hospital Medical Schools.

THE list of awards of entrance scholarships at this medical school, examination held Sept. 20th and 21st, is announced as follows:—*Open Scholarships in Natural Science* (value £145), W. L. Cowardin. *Open Scholarships in Natural Science* (value 50 guineas each), E. W. Archer, A. B. Porteous, T. A. F. Tyrrell. *University Scholarships* (of 60 guineas each), C. H. Rothera, B.A., Emmanuel College, Camb.; and P. P. Laidlaw, B.A., St. John's College, Camb., and K. A. Lees, B.A., King's College, Camb. (equal). The Epsom Scholarship of £145 was awarded to T. C. C. Evans, on the nomination of the headmaster.

### The Royal Academy of Medicine in Ireland.

THE annual meeting of the Royal Academy of Medicine in Ireland will be held on Friday, the 14th inst., when, in addition to the usual election of the various sectional Councils for the ensuing year, the post of general secretary, vacant through the resignation of Mr. J. B. Story, F.R.C.S., will be filled. Three very strong candidates are in the field—Dr. Craig, Registrar of the Royal College of Physicians; Dr. Cronyn, medical officer to the South Dublin Union; and Dr. Travers Smith, physician to the Richmond Hospital. It is expected that the voting will be very close, and much interest is manifested in the result.

### 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 30th ult., at 429, Strand, London, W.C. There were present Dr. de Havilland Hall (in the chair), Mr. F. S. Edwards, Dr. F. J. Allan, Dr. J. Pickett, Dr. F. S. Palmer, Dr. J. Brindley, James, Dr. J. W. Hunt, Dr. St. Clair B. Shadwell, Dr. W. Knowsley Sibley, Mr. William Thomas, and Dr. Alfred S. Gubb. The records of the Society for the current year so far agree closely with previous experiences. In the first half of every year the sickness claims list was found to be heavy, while in the second half the amount of claims is always sufficiently low to leave a substantial margin on the year's working. In this way the funds of the Society have steadily grown until they now amount to over £180,000. As a considerable number of the members are permanently incapacitated and thus compelled to draw sickness pay, all the year round, a large sum is expended in providing what is practically a permanent provision for those who will never again be able to perform professional work. The letters read from those to whom this permanent allowance is made leave little doubt that this is one of the most valuable branches of the operations of the Society. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

### Royal College of Physicians of Ireland.

THE annual meeting of the Royal College of Physicians of Ireland will be held on Tuesday, the 18th inst., in the College Hall. The election of officers and

committees for the ensuing year will take place. It is expected that Dr. W. J. Smyly will be elected President in succession to Sir Arthur Macan, whose term of office has expired. The annual dinner will be held the same evening.

#### Childhood Society.

A COURSE of public lectures will be given in the Library of the Sanitary Institute, 72 Margaret Street, W., at eight p.m.:—Thursday, October 20th, "Discussion on Physical Deterioration," opened by E. W. Brabrook, C.B., F.S.A., Mrs. A. Watt Smyth, Robert Hutchison, M.D., G. E. Shuttleworth, M.D., Francis Warner, M.D.; chairman, Sir T. Lauder Brunton, LL.D., M.D., F.R.S. Thursday, October 27th, "Physical Condition of Working Class Children," by T. J. Macnamara, LL.D., M.P.; chairman, Rt. Hon. Sir John Gorst, K.C., M.P. Thursday, November 10th, "Mental Hygiene in Childhood," by T. B. Hyslop, M.D., M.R.C.P. Edin.; chairman, Sir James Crichton-Browne, LL.D., M.D., F.R.S.; Thursday, November 24th, "Education of Girls," by Miss M. E. Findlay, B.A.; Chair, Miss Alice Ravenhill.

#### Trinity College, Dublin.

THE school for the Royal Medical Services, which was started in Trinity College during the beginning of the year, and has proved so successful at the R.A.M.C and I.M.S. examinations, will commence its second session on November 7th. The object of the school is to enable Irish Medical students, who desire to adopt the Army or Navy as a profession, to prepare themselves in Ireland. Already the school has begun to attract candidates from the other side and, promises to take an important educational position, combining, as it does, clinical work with lectures and practical work, and offering special facilities for operative surgery.

#### University of Liverpool.

At a recent meeting of the Council of the University the following appointments were made in the Faculty of Medicine:—Lectureship in dermatology, Leslie Roberts, M.D.; lectureship in laryngology, John Middlemas Hunt, M.B.; lectureship in clinical pathology, E. E. Glynn, M.B.; lectureship in neuro-pathology W. B. Warrington, M.D., M.R.C.P.

#### Charing Cross Hospital Medical School.

THE following entrance scholarships have been awarded at Charing Cross Hospital:—The Epsom Scholarship (100 guineas), to Mr. L. H. Taylor; the Livingstone Scholarship (100 guineas), to Mr. C. J. Fox; the Huxley Scholarship (55 guineas), to Mr. H. F. L. Hugo; Universities Scholarships (each 72 guineas), to Mr. C. Beards and T. W. Wade. Entrance scholarships have also been awarded to Mr. L. M. Webber (60 guineas), Mr. E. S. Calthrop (40 guineas), Mr. R. G. Dainty (30 guineas), and a Universities' Exhibition of 36 guineas to Mr. J. J. S. Rowe.

### PASS LISTS.

#### The Royal University of Ireland.

*The First Examination in Medicine.*—The Examiners have recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

*Pass.*—Charles Alexander, Edgar M. Condy, Vincent Cosgrave, John Counihan, Caroline J. Crawford, John B. Crawford, Edmund Doherty, Edward Dowling, James E. English, Charles A. Farrell, James Ferguson, B.A., Cornelius J. Halpin, Robert Harrington, William F. Hooper, George E. Hull, Patrick Keelan, Sarsfield P. Kerrigan, Caroline V. Lowe, William C. McCullough, Michael McGing, John J. McGrath, James A. McMurtry, Michael J. Mulligan, Arthur P. O'Connor (Sch.), James M. O'Connor, John P. J. O'Connor, Samuel P. Rea, John Seymour, William H. Sheffield, William S. R. Steven, Thomas Taylor, Eustace Thorpe, Verner Wiley.

*Exempt from further examination in Botany and Zoology.*—Henry A. Gillespie.

The undermentioned candidates have qualified on their answering to present themselves for the further examination for honours. Those qualified in two or

more subjects may present themselves for the Honour Examination in all subjects:—

Charles Alexander, John Counihan, Caroline J. Crawford, Edward Dowling, James E. English, Charles A. Farrell, James Ferguson, B.A., Sarsfield P. Kerrigan, Caroline V. Lowe, John J. McGrath, Michael J. Mulligan, Arthur P. O'Connor (Sch.), James M. O'Connor, Samuel P. Rea, William H. Sheffield, S. R. Steven.

*The Second Examination in Medicine.*—The examiners have recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

*Upper Pass.*—Joseph D. Cummins, Thomas S. S. Holmes, Marshall F. Huston, John J. Kearney, Robert G. Kevin, James B. Lapsley, Michael Waldron. All the above candidates may present themselves for the further examination for Honours.

*Pass.*—Raphael N. Berman, Arthur R. Boyd, William Bradbury, Daniel Broderick, Edwin B. Brooke, Thomas G. Buchanan, Joseph D. G. Burke, Robert J. Clarke, Mary Cowley, Laurence J. Curtin, James Dewar, James Dooley, Joseph S. Doyle, William Faith, Patrick Ferris, Eleanor E. Finegan, Thomas Forsle, James B. Horgan, Arthur H. Joy, Richard G. C. M. Kinkead, Richard R. Kirwan, Robert Lavallin, Solomon Levy, Thomas P. Linehan, Wiclif McCready, Augustine P. MacMahon, George H. Martin, James F. Neary, Edward O'Reilly, William L. O'Reilly, Christopher F. X. O'Sullivan, John J. Sheil, Hans C. Swertz, Espine J. Ward.

*Exempt from further examination in Anatomy and Physiology.*—John Clarke, Charles Murphy, Alexander Stevenson.

*Exempt from further examination in Practical Chemistry.*—William Drowne, David O'Sullivan.

#### Glasgow University.

At the recent professional examinations for the degrees of M.B., Ch.B., the following candidates passed with distinction in the subjects indicated:—

*First Examination.*—In Botany and Physics: John Cruickshank, Peter Russell M'Naught, Albert Rutherford Paterson. In Zoology and Physics: David Alexander Thomson, M.A. In Zoology and Chemistry: Robert Rankin Bow. In Botany: David Young Buchanan, Frank Crombie Macauley, Frank Needham Marsh. In Zoology: William Anderson, William M'Kendrick. In Physics: Walter Gilmour, John William M'Nee, William Wilson Rorke. In Chemistry: Walter Hermann Kiep, William Aikman Muir, John Young. *Second Examination.*—In Physiology: John Anderson, M.A., B.Sc. In Materia Medica and Therapeutics: Peter Mitchell, M.A. *Third Examination.*—In Pathology and Medical Jurisprudence and Public Health: William Blair Morton Martin. In Medical Jurisprudence and Public Health: Elizabeth Maud M'Vail.

The following passed the first professional examination for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subjects indicated (B., Botany; Z., Zoology; P., Physics; C., Chemistry):—

Archibald Aitchison (C.), David Anderson (C.), James George Anderson (B., P.), William Anderson (Z., C.), Thomas Archibald (B., P.), William Hunter Stirling Armstrong (B., Z.), Alexander Ballantyne (B., Z., C.), William Barr (B., P., C.), Charles Bennett (B., P.), Robert Rankin Bow (Z., C.), Charles Brash (Z., C.), William Barrie Brownlie (B., P.), David Young Buchanan (B., P., C.), John Adam Gib Burton (B.), Hector Mackay Calder (B., Z., C.), John Cameron (C.), Donald James Clark (B., P., C.), James Lang Cochrane (B.), Alexander Johnston Couper (C.), Rutherford Cramb (B.), John Cruickshank (B., P.), James Cowie Dick (C.), Charles Duguid (B.), William Hunter Duncan (Z.), Philip Figdor (B.), Robert Dunlop Black Frew (B., Z.), David Gibson (B.), Alexander Gordon Gilchrist (B., P.), Walter Gilmour (B., P.), George Stevenson Gordon (B., P.), Hugh Macvicar Gossman (C.), Edward O'Driscoll Graham (B., C.), John Granger (B., P.), George Haddow (B.), William Hamilton (P., C.), Michael Harkin (B., Z., P., C.), John Primrose Hay (B., Z.),

John M'Lean Hendry (B., Z.), Stephen John Henry (B., P.), James Hall Hislop (C.), William Alexander Hislop (B.), Colin Hunter (B.), Cochran Johnston (B., Z.), Walter Hermann Kiep (B., Z., P., C.), John Parlane Kinloch (B.), David Neilson Knox (B., P.), John Lang (B., P.), George Smith Livingston (Z.), William Charles Macartney (B.), Frank Crombie Macaulay (B., P.), Robert M'Carlie (B.), William M'Connell (B., P.), Donald M'Dougall (B., Z.), Neil MacInnes, M.A. (C.), William M'Kendrick, (B., Z.), Francis William Mackichan (Z., C.), Thomas Mackinlay (B., P.), Alexander M'Kinnon, (B., P.), John James Mackintosh (B., Z.), John MacMillan (Z., C.), Peter Russell M'Naught (B., P.), John William M'Nee (B., P.), Murdo MacPhail (B., Z., C.), Thomas Marlin (B., P.), Wm. Aubrey Layard Marriott (B.), Frank Needham Marsh (B., P.), David Rogerson Mathieson (B.), Donald Meek (B., Z.), William Spence Melville (B.), Kenneth Chisholm Middlemiss (B., P.), Robert Stewart Miller (P.), John Mowat (B., Z.), William Aikman Muir (B., C.), Charles Sutherland M'Kay Murison (Z.), Charles Allison Murray (B.), Watson Noble (B., P.), Bernhardt Papiermeister (B., Z.), Albert Rutherford Paterson (B., P.), Adam Patrick, M.A. (C.), Murray Purvis (B., P.), Edward Quigley (B., C.), Richard Rae (C.), Henry Nimmo Rankin (B., Z., P., C.), Nicol M'Nicoll Rankin (P., C.), John Robertson (Z.), Robert Charles Robertson (B., P.), Alfred Roemmele (B., P.), William Wilson Rorke (B., P.), William Rutherford (B., P.), Robert Ephraim Selby (C.), William Alexander Sewell (B., P.), James Brown Sim (B., C.), James Johnston Sinclair (B.), James Stewart Somerville (B.), Alexander Stewart (B.), Donald Stewart (B., Z.), Edward Ernest Stewart (B., P., C.), Robert Wilson Sutherland (B., P.), David Taylor (B., P.), Duncan Macnab Taylor (B., P.), David Alexander Thomson, M.A., (B., P.), John Shedd Thomson (B., P.), Arthur Turnbull (B., C.), Robert M'Nair Walker (B., P.), William Samuel Waterhouse (B.), Tom Paul Watson (Z., C.), Harold Wellwood (Z., C.), James Brown Whitfield (B., P.), William Crowley Whittingham (B., P.), Charles Percival Williamson (C.), John Alexander Wilson (B., P.), Henry Joseph Windsor (B., P.), Hugh Young (Z., C.), John Young (Z., C.). *Women*: Mabel Foley (B., Z.), Euphemia Adamson Hay (B., Z.), Ella Smith Hill, M.A. (B., Z.), Jeanie Walker Jones (B., Z.), Honoria Somerville Keer (B., Z.), Janet Nannie Macvea (B.), Mary Cochran Mitchell (B., Z.), Flora Morrison (C.), Jessie Deans Rankin (B., Z., C.), Olive Robertson (C.), Winifred Margaret Ross (B., Z., C.), Jessie Capie Russell (B., Z.), Margaret Elizabeth Rutherford (P.), Jemima Wallace (B.), Ethelwyn Mary Walters (B., Z.).

The following passed the third professional examination for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subjects indicated (P., pathology; M., medical jurisprudence and public health):—

Andrew Blair Aitken (M.), George Allison Allan (M.), Andrew Woodroffe Anderson (P.), John Bain, M.A. (P., M.), George Thomson Bogie (M.), Charles Burns (P.), John Miller Hopkins Caldwell (P.), Donald Livingstone Carmichael (M.), Charles Game Angus Chislett (P.), John Shaw Dunn, M.A. (M.), William Gilchrist (P., M.), John Isdale Greig, M.A., B.Sc. (P., M.), William Grier (M.), John Hammond (P.), Charles Francis Dyer Hammond (P.), James Duncan Hart (M.), Frank Hauxwell (M.), Robert M'Gowan Hill (M.), Ralph Vincent Howell (P.), Alexander Hunter (P.), David Guthrie Hunter, M.A. (P., M.), James Hunter (M.), Archibald Yuill Hutchison (M.), Harry Stewart Hutchison, B.Sc. (P., M.), Arnold Ernest Jones (P., M.), George Notman Kirkwood (M.), Alexander Leggat (P., M.), Thomas M'Cosh (M.), Duncan M'Ewan (M.), John Macintyre (P.), William Macleod (M.), John M'Millan (P., M.), Hugh MacNaught (M.), Norman Smith MacNaughtan (M.), Richard Cameron Macpherson (P., M.), William Blair Morton Martin (P., M.), Robert May (P., M.), Henry Joseph Milligan (P.), Gavin Denholme Muir (P.), John Dunn Nisbet (P.), Patrick Joseph O'Hare (M.), Thomas Hood Rankin (P.), Thomas

Thomson Rankin (M.), John Reid (P.), William Rolland (M.), John Cooper Russell, M.A. (P., M.), Edward Louis Augustin Sieger (P.), Arthur Anderson Stewart (M.), Daniel Stewart (P., M.), John Logan Stewart, M.A. (P., M.), Joseph Roderick Sutherland (P., M.), Thomas Thom (M.), William Lind Walker, M.A. (M.), Alexander MacMillan Watson (P.), James Wyper (M.). *Women*: Jeannie Thomson Clark (M.), Elizabeth Maud M'Vail (M.), Jessie Deans Rankin, M.A., B.Sc. (M.), Jane Reid Shaw (P.), Mary Spence (P.), Christina Gibson Thomlinson (M.).

The following passed the second professional examination for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subjects indicated (A., anatomy; P., physiology; M., materia medica and therapeutics):—

Thomas Montgomery Anderson (A., P.), John Anderson, M.A., B.Sc. (A., P., M.), Thomas Barbour, B.Sc. (M.), William Rome Cammock (A., P., M.), George Campbell (A., P., M.), John Sowers Clark, M.A. (M.), Thomas Lawson Craig (M.), Robert Donald (A., P., M.), James Richan Drever, M.A. (A., P., M.), Richard John Driscoll (P.), James Dunbar (P.), Ernest Milne Eaton (M.), William Miller Fairlie (P.), John Ferguson (A., P., M.), Thomas Henderson Forrest (A.), James Wilfred Georgeson (A., M.), William Gilfillan (A., P., M.), Arnold Harris Gray (M.), William Towers Hardie (P., M.), Lawrence Hislop (A.), John Keys (M.), James Dunlop Kidd (M.), James Towers Kirkland (A.), Robert Wright Leckie (M.), George Ligertwood (P.), Ernest Bowman Macaulay (A.), Alexander M'Call (A., M.), Thomas M'Cricrick, M.A., B.Sc. (A., P.), William Anderson M'Kellar (A., P.), Murdo Duncan Mackenzie (A., P.), Alister Argyll Campbell M'Neil, (M.), Robert Marshall (M.), Allan Frederick Miller (A.), James Robertson Mitchell (A., P., M.), Peter Mitchell, M.A. (M.), Robert Wright Mitchell (P.), James Hogg Paul (M.), Arthur Geoghegan Paxton (A.), Daniel M'Kinlay Reid (P., M.), Murdock Mann Rodger (P.), Alfred Cecil Sharp (M.), James Charles Donaldson Simpson (A.), James John Sinclair (M.), William Smellie (M.), John Stevenson (M.), John Torrance Weir Stewart (P.), Robert Todd (A., P.), Martin Turnbull (A.), George Wallace (A.), Hugh Ferguson Watson (P.), Hugh White (A., P.), David John Williams (A., P.), Thomas Winning, M.A., (P.), Moses Youdelevitz (M.). *Women*: Jeannie Montgomery Andrew (M.), Annie Rennie Hird (P.), Katharine Robina Margaret Lucas (M.), Edith Oversby (A.), Vera Dagmar Reis (M.), Margaret Baillie Taylor (A.).

#### Conjoint Examinations in Ireland.

CANDIDATES have passed the September, 1904, Preliminary Examination as undernoted:—

*With Honours*.—Miss Harriet MacFaddin, Messrs. E. C. Deane, J. F. Gibbons, J. M. Gage, and N. Purcell. *Passed*.—Messrs. J. J. Clarke, H. Gray, J. T. Heffernan, B. Hill, H. Hunt, W. R. Kelly, C. Kelsall, E. P. McSweeney, W. R. O'Kieffe, W. P. H. Parker, T. A. Peel, C. D. K. Seaver, H. B. Smyth, P. T. Warren, and Miss C. F. Williamson. The Supplemental Preliminary Examination will be held on the 31st inst.

#### The Guild of St. Luke.

THE Annual Medical State Service in St. Paul's Cathedral, organised by the Guild of St. Luke, will take place this year on October 24th, at 7.30 p.m., when the Bishop of Southwark will preach the sermon. A choir of 300 voices, provided by the London Gregorian Choral Association, will render the music. Members of the medical profession are invited to attend in academical robes. Admission to the space under the dome will be by tickets only.

#### Public Vaccinators.

THE annual dinner of the Association of Public Vaccinators of England and Wales will be held at the Hotel Cecil, Strand, London, W.C., on Friday, October 28th, at 7 p.m. All communications should be addressed to Mr. Charles Greenwood, 1 Mitre Court Buildings, Temple, E.C.

## 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.

**SLEEPING SICKNESS (Taunton).**—In 1901 trypanosomes were discovered in the blood of a European by Dr. J. E. Dutton, Walter Myers Fellow, while on an expedition of the Liverpool School of Tropical Medicine to Gambia. In consequence of this observation an expedition composed of Drs. Dutton and Todd, was sent in 1902 by the school to Senegambia to prosecute further researches in trypanosomiasis. The detailed report of that expedition was published in 1903, and contained a study of the pathogenetic trypanosomata of man and animals, several new species being described.

### "THE LAST DAYS OF SPECTACLES."

The newspaper report of a "new method" of treating errors of refraction under this heading refers to "Dr. Stephen Smith of the Antivivisection Hospital, Battersea." It is stated that the globe of the eye can be so altered by massage as to remedy defective forms and so restore normal sight. Most medical men will suspend their judgment until the case is brought to their notice through the legitimate channel of the medical societies and the medical journals.

**DR. PROCTOR.**—The "Dispensary Doctor" is not obliged to give any such certificates.—The Workman's Compensation Act of 1897 provides that an injured workman claiming under the Act shall, if required to do so by his employer, present himself for examination to a duly qualified practitioner, who is to be provided and paid by the employer. We do not know of any official scale of charges that has been drawn up for such cases.

**DR. W. DAVIES.**—We are not in a position to advise you as to the probabilities of practice in South Africa, but we learn from our contemporary *The South African Medical Record*, that it has been found desirable to open an agency department in connection therewith at Capetown, and that practices are both wanted and for disposal.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 13th.

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

**SOUTH-WEST LONDON MEDICAL SOCIETY** (Bolingbroke Hospital, Wandsworth Common).—8.45 p.m. Paper:—Dr. de H. Hall: Errors of Diagnosis.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. J. Berry: Clinique. (Surgical.) 5.15 p.m. Dr. H. Mackenzie: Graves's Disease and its Treatment.

THURSDAY, OCTOBER 14th.

**BRITISH GYNECOLOGICAL SOCIETY** (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Edge, Mr. F. Jordan, Dr. W. Duncan, Dr. Macnaughton-Jones, and others. Paper:—Mr. C. Martin: The Treatment of Severe Prolapse by Extirpation of the Uterus and Vagina.

**HARVEIAN SOCIETY OF LONDON** (Stafford Rooms, Tithebarn Street, Edgware Road, W.).—8.30 p.m. Mr. C. B. Keetley on "Plastic Surgery." (Harveian Lecture.)

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchingson: Clinique. (Surgical.) 5.15 p.m. Dr. W. J. Home: Pachydermia Laryngis.

**MOUNT Vernon HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Introductory Address:—Dr. G. A. Gibson (Edinburgh): Certain Aspects of Pleurisy. (Post-Graduate Course.)

FRIDAY, OCTOBER 14th.

**CLINICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—8.30 p.m. Presidential Address. Papers: Dr. W. Harris and Mr. W. W. Low: The Cure of Infantile Paralysis of the Shoulder by Nerve-grafting (with case to be exhibited).—Mr. W. G. Spencer: Cases of Inflammation in and around the Liver.—Dr. P. D. Turner and Mr. E. Johnson: Traumatic Axillary Aneurysm successfully treated after Extravasation had occurred by Proximal Ligature.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Dr. W. J. Home: Clinique. (Throat.)

## Vacancies.

**Devon County Asylum.**—Second Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent, the Asylum, Exminster.

**Mickleover, Derby, County Asylum.**—Senior Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

**Kent County Asylum.**—Third Assistant Medical Officer. Salary £140 per annum, with board, quarters, attendance and washing.—Applications to the Medical Superintendent.

**Horton Infirmary, Banbury.**—House Surgeon. Salary £80 per annum, with board and residence in the Infirmary. Applications to the Honorary Secretary, 21 Marlborough Road, Banbury.

**West Suffolk General Hospital, Bury St. Edmunds.**—House Surgeon. Salary £100 per annum, with board and lodging. Applications to the Secretary.

**East London Hospital for Children and Dispensary for Women, Shadwell, E.**—Resident Medical Officer. Salary £100 per annum, with board, residence, and laundry. Applications to Thomas Hayes, Secretary.

**Somerset and Bath Asylum, Cotford, Taunton.**—Assistant Medical Officer. Salary £160 per annum, with furnished apartments, board, fuel, lighting, and washing. Applications to the Medical Superintendent.

**Brecon and Radnor Lunatic Asylum, Talgarth, Breconshire.**—Medical Superintendent. Salary £450 per annum, with fully furnished house, coal, light, washing, and garden produce. Applications to J. H. Evans, Secretary.

**Metropolitan Asylums Board.**—Male Assistant Medical Officer. Salary £150 per annum, with rations, lodging, attendance, and washing. Applications at the Office of the Board, Embankment, London, E.C.

**Darlington Hospital and Dispensary.**—House Surgeon. Salary £120 per annum, with board and lodging in the Institution. Applications to the Secretaries, 48 Stanhope Road, Darlington.

**Down District Lunatic Asylum.**—Junior Male Assistant Medical Officer. Salary £100 per annum, with furnished apartments, &c. Applications to the Resident Medical Superintendent.

## Appointments.

**ALWAY, W. R., M.B. Toronto,** Clinical Assistant to the Chelsea Hospital for Women.

**ANDERSON, A. W., M.B., Ch.B. St. And.,** has been appointed Junior House Surgeon to Liverpool Infirmary for Children.

**COPE RICARDO, M.B.C.S., L.R.C.P.,** House Surgeon to the Brighton and Hove, and Preston Dispensary, Northern Branch.

**CROSS, W. F., M.B.C.S. Eng., L.R.C.P.,** Assistant Chloroformist to St. Bartholomew's Hospital.

**ETHINGTON-SMITH, R. B., B.S. Cantab.,** Senior House Surgeon to St. Bartholomew's Hospital.

**FLAVELL, J. M., M.B.C.S. Eng.,** Clinical Assistant to the Department of Electro-Therapeutics, St. Bartholomew's Hospital.

**GUNNING, C. J. H., M.B.C.S., L.R.C.P. Lond.,** Second Assistant Medical Officer to the Kensington Infirmary.

**HORNE, W., JONES, M.D. Cantab.,** Clinical Assistant to the Department for Diseases of the Throat and Nose, St. Bartholomew's Hospital.

**HOWELL, C. M. H., M.B.C.S. Eng., L.R.C.P. Lond.,** Senior House Physician to St. Bartholomew's Hospital.

**HURDON, B., M.B.C.S. Eng., L.R.C.P. Lond.,** Junior House Physician to Bartholomew's Hospital.

**JOHNSON, W. CROSS, M.B., Ch.B. Vict.,** Honorary Physician to Pendleton Branch Dispensary of Salford Royal Hospital.

**JONES, J. M., M.D. Michigan,** Clinical Assistant to the Chelsea Hospital for Women.

**JUDSON, A. H., M.D. Toronto,** Clinical Assistant to the Chelsea Hospital for Women.

**LUDWARD, H. D., M.B., B.C. Cantab.,** Senior House Surgeon to St. Bartholomew's Hospital.

**LEWIS, J. W., L.R.C.P., L.R.C.S. Edin., L.F.P.S.G.,** Certifying Surgeon under the Factory Act for the Brynamman District of the counties of Carmarthen and Glamorgan.

**PAINE, H. RICHARD, M.B.C.S., L.R.C.P. Lond., L.D.S.,** Assistant Dental Surgeon to the National Dental Hospital.

**SAWYER, JAMES E. H., M.A., M.D. Oxon., M.R.C.P.,** has been appointed Pathologist at the General Hospital, Birmingham.

## Births.

**McNABB.**—On October 7th, at the Royal Navy Hospital, Plymouth the wife of Fleet Surgeon D. McNabb, R.N., of a daughter.

**SELLER.**—On October 4th, at 154 Commercial Road, London, E. the wife of J. Douglas Sellar, M.B.C.S., L.R.C.P., of a daughter.

## Marriages.

**ANNING-HAIGH.**—On October 5th, at the Parish Church, Oak, Yorks, George Paul Anning, M.B.C.S. Eng., L.R.C.P. Lond., of Kirkstall, Leeds, to Clara Evelyn, elder daughter of Frederick Haigh, late of The Holme, Bramhope, now of Lyddon Terrace, Leeds.

**BATLEY-HAYLETT.**—On October 6th, at St. Mark's, Dalston, Albert Brook Batley, M.B.C.S. Eng., L.R.C.P. Lond., son of the late Joseph Batley, of Huddersfield, to Edith May, daughter of the late Albert Haylett, of Brentford.

**FOTHERBY-BARRETT.**—On October 5th, at St. John the Baptist's, Kensington, Henry Arthur Fotherby, L.R.C.P., M.B.C.S., of Headcorn, Kent, son of H. I. Fotherby, M.D. Lond., of Westhorpe Cote, Reigate, to Jane (Bee), eldest daughter of Dr. A. E. Barrett, of Holland Park Avenue, London.

**SCOTT-IRWIN.**—On Sept. 29th, at St. Mark's Church, Armagh, by his Grace the Lord Primate, assisted by Rev. C. E. Scott, Rector of Busbrooke, Dio. Cloyne, Rev. H. G. Scott, Rector of Oregan, Dio. Armagh (brothers of the bridegroom), and Rev. C. K. Irwin, rector of Brandy Dio. Armagh, (brother of the bride), James Crossle Scott, M.D. Dubl., youngest son of the late William Scott, M.D., B.C.S. Eng., of The Bawn, Aughnacloy, co. Tyrone, to Elizabeth Ensor, eldest daughter of the Ven. the Archbishop of Armagh.

## Deaths.

**BISHOP.**—On October 7th, at Edinburgh, Isabella Lucy Bishop, F.R.G.S., F.R.S.G.S., daughter of the late Rev. Edward Bird, rector of Wyton, Huntingdonshire, and widow of John Bishop, M.D., Edinburgh.

**COOPER.**—On Oct. 9th, at East Twickenham, Eliza Mary Cooper, widow of Horace Cooper, M.B.C.S., J.P., of Marlborough, Wilts, aged 84 years.

**ORTON.**—On October 7th, at Bedworth Warwickshire, Edward William Orton, M.B.C.S. Eng., L.R.C.P. Edin., aged 62.

**WRIGHT.**—On October 9th, at The Croft, Hinderwell, Yorks, Jane, widow of Alexander Wright, M.D., F.R.C.S., aged 80 years.



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## Original Communications.

### ON THE TREATMENT OF INOPERABLE CANCER BY HYPODERMIC MEDICATION. By JOHN A. SHAW-MACKENZIE, M.D.Lond.

In the year 1902 I was first led to adopt the method of hypodermic medication in the treatment of disease. I had long taken an interest in the medicinal treatment of uterine fibroids, and for some years I had been desirous of finding a substitutive method of administering, among other drugs, iodide of potassium and iodine. When, therefore, Messrs. Merck, of Darmstadt, introduced iodopin—a combination of iodine and sesame oil—as an efficient substitute for iodide of potassium generally, and administered subcutaneously, without producing iodism, it occurred to me to adopt this method in the treatment of uterine fibroids and menorrhagia. The opportunity for treating cases in this way was shortly after kindly given me by Dr. John Shaw, at the North-West London Hospital, and together we obtained complete relief of symptoms in some cases with more or less shrinkage of the tumour, and probably, in at least one case, its disappearance. No particular local or general inconvenience follows the injections, which are given well into the intracellular tissue of the buttock in doses of 3 to 10 c.c. The treatment is a continuation of the older iodine one; only as it seems to me by a more convenient, rapid and direct method of administration of the drug. It does not confine the patient to bed or the house, nor is there apparently any disagreeable effect. In another case under my care rapid shrinkage at first, and later almost complete disappearance of a large and undoubted uterine fibroid, for which hysterectomy had been a few days before independently recommended, took place under this treatment. This patient at the time, mentioned to me that a friend of hers had obtained great benefit while abroad from hypodermic injections of iron, after large quantities of iron mixture had been taken here without apparent benefit. The preparation in this case was one of arsenic and iron; both this and various preparations readily obtained both here and abroad approximating to that of Dr. Zambelletti, of Milan. Extensive trials of these with or without strychnia have since been made by Dr. Shaw and myself, and have proved to be beneficial in certain cases of anæmia, neurasthenia and malaria. Again we made trial of various preparations of mercury, and a solution of the benzoate which I obtained from Messrs. Merck has proved satisfactory. Both the iron and arsenic, and

mercury are injected into the muscular tissue of the gluteus. It is impossible here to enumerate the many cases in which the above hypodermic preparations as well as others, as, for example, strychnine and spermin, have been singly or alternately employed, but encouraging results have been obtained in some cases of chronic endometritis, pelvic inflammation in women, rheumatoid and septic arthritis, locomotor ataxy, and improvement in one case of disseminated sclerosis.

*Hypodermic Medication in Inoperable Cancer.*—Encouraged by the results of hypodermic medication in the foregoing cases I was led to try various preparations, including the known injections of the cacodylates and of arsenic in cases of inoperable cancer, but beyond some temporary improvement in the general health, no manifest improvement was obtained. The problem was to find some preparation which would give relief. In course of time at last, decided relief, removal of pain and fœtor, with apparent arrest of disease, was obtained in two cases of inoperable cancer under the care of Colonel T. Ligertwood, C.B., M.D., in the Infirmary of the Royal Hospital, Chelsea, as already recorded by Colonel Ligertwood and myself in the July number, 1904, of the *Journal of the Royal Army Medical Corps*. The first case was a case of carcinoma of the tongue in an old soldier which was treated by hypodermic injections of soap solution originally recommended by Mr. John Holden Webb, Melbourne. The second case was that of carcinoma of the neck, treated by hypodermic injections of chian turpentine—a new method of treatment so far as we know, the drug itself having been originally introduced by the late Prof. Clay, of Birmingham, in the treatment of cancer.

Aware of disappointments with chian turpentine recorded in the past, its employment in this case suggested itself from the recollection of the complete recovery in 1891 of a case of presumed and advanced cancer of the uterus in which Colonel Ligertwood and I had recommended its internal administration, subsequently to the opinion at the time of an eminent authority (since deceased) of the hopeless nature of the case; while the combination of iodine and sesame oil in iodopin suggested a similar combination of chian turpentine for hypodermic purposes. It may be recollected that twenty-five years ago the late Prof. Clay strongly recommended chian turpentine by the mouth in the treatment of cancer, and "if permanent cure was not obtained, an amount of relief secured to patients which had not been afforded by any other plan." The treatment was condemned by others and fell into disuse, and yet the results obtained by Prof. Clay in certain cases cannot be doubted. Since the publication of the method

of hypodermic administration by Colonel Ligertwood and myself, Mr. Augustus Clay, the son of the late Prof. Clay, has informed me that he had never heard of chian turpentine being injected subcutaneously, but at the same time he remarks that he can quite understand how very much more trustworthy the treatment may become under this method. Accounting for the difference in the results which followed the internal administration of the drug by his father and others, he suggests that in all probability the explanation was to be found in the fact that the drug was unassimilated, inasmuch as large masses were passed undigested by the rectum. This was noticeable in the pill form of administration; the emulsion giving far better and quicker results. Mr. Clay asserts that he is now using the injections in a case of cancer of the rectum. The patient had previously been taking large doses of morphia, but has had none since the commencement of this treatment, and so far relief from pain has been obtained.

*Technique.*—The injections of chian turpentine are administered deeply into the subcutaneous tissues. Experience has shown that the buttock is a suitable place. Given deeply into the cellular tissue they occasion little or no inconvenience or pain. The muscular tissue itself must be avoided as injections into it cause pain and sense of tension. I prefer the "all glass" syringe made by Messrs. Burroughs Wellcome. The special features of this appliance are that it is separable into parts which, with the needle, can be sterilised by boiling first, before use. The method which I adopt, is to keep a separate needle for each patient. A somewhat stout needle is necessary. An irido-platinum needle is preferable, being not liable to break in the deeper injections into the gluteal region. The same applies to the intra-muscular injections of iron, arsenic, and mercury. The site of injection is first sterilised with some antiseptic solution; after which a piece of ice is placed upon the surface, or local anaesthesia induced. The former is a simple means of abolishing all pain of insertion of the needle, and though this may seem a minor detail, upon it depends, in many cases, a continuance of hypodermic medication.

*Dosage.*—Colonel Ligertwood and I found by experience that 5 minims of a 20 per cent. combination of chian turpentine with olive oil, obtained from Messrs. Southall Bros. and Barclay (Birmingham), is the quantity to begin with, increasing by 5 minims on alternate days up to 60 minims. In our first case there was considerable rise of temperature following the third and fourth injections of 15 minims and 20 minims respectively. Some doubt existed as to the cause, inasmuch as in subsequent cases the same has not been noticed when gradually pushed to the full. Messrs. Southall now supply the injections of chian turpentine in small stoppered phials ready for use, as well as the emulsion for internal administration.

*CASE I.*—*Carcinoma of the neck* in an old soldier in the Infirmary of the Royal Hospital, Chelsea, under the care of Colonel Ligertwood. There was a large hard fixed mass, ulcerating in places, and bleeding readily over the middle of the right sterno-mastoid, extending up towards the mastoid process, under the ramus of the jaw and over the trachea in front. The head was forced over to the opposite side, great pain was complained of, and swallowing was becoming difficult. It had commenced primarily as a pimple in November, 1903,

attributed to rubbing of the coat collar, and was evidently growing. Medical history sheet clean. Malaria in India forty years ago. Microscopic examination of a small piece taken from the edge of the ulceration proved it to be epithelioma. On January 25th, 1904, 5 minims of a 20 per cent. combination of chian turpentine in olive oil (sterilised) were injected subcutaneously into the arm, the dose being increased by 5 minims on alternate days till 20 minims were given. The third injection of 15 minims was followed by a rise of temperature to 102°, returning to normal in the morning; while after 20 minims it rose to 103·6°, necessitating reduction of the dose to 5 and 10 minims in future, once or twice a week, followed by a rise of temperature to 100° or thereabouts. Briefly, in this case all pain went from almost the first injection; the extensive redness of the surrounding surface, which reached to above the mastoid in one direction and on to the upper chest in the other, rapidly subsided, leaving a faint, purple discoloration, limited to the immediate neighbourhood of the growth; the ulceration decreased and the discharge assumed a purulent character free from all smell; the head was no longer tilted and could be moved freely in all directions, the difficulty in swallowing passed away, and at the end of a month the size had diminished astonishingly in all directions. On May 30th the tumour was about the size of a hen's egg, remaining stationary, but occasioning no inconvenience; slight further shrinkage had continued from week to week with purulent but inoffensive discharge from the ulcerated surface. The patient was in the convalescent ward and going out of doors regularly. As I have since heard through Colonel Ligertwood, he had begun to fail in August, took to his bed, and died; but though there had been some hæmorrhage at times, there was no pain or extension of growth.

*CASE II.*—On August 10th, 1904, Mr. — consulted me. He had been under several eminent surgeons and physicians in town. He was suffering from a rapidly growing pelvic and inoperable tumour which was first noticed in January last. I found a hard solid tumour filling the abdomen almost up to the ensiform cartilage, and the right thigh and leg were enormously distended. There had been already some hæmorrhage from the bladder on several occasions. He was unable to retain solid food. His wife was carrying out X-ray treatment for him in the country, but his appetite had failed; his weakness was great, and the surgeons in town had expressed the opinion that the X-rays had not arrested the growth. I wrote to his medical man in the country, suggesting trial of chian turpentine injections and also of emulsion of the same by the mouth, which he kindly agreed to carry out. August 22nd.—I heard from Mrs. — that so far the injections had worked a wonderful improvement, that his leg was softer, his appetite better and that he could retain solids. September 9th.—I again heard that he was really very much better; that the tumour had receded from the stomach in a really wonderful manner, and that he could eat solids as well as ever and enjoy them. September 10th.—His medical man wrote to me corroborating the above. September 17th.—Mr. — came up to town to-day to see me, and the general improvement is very marked. The abdomen is no longer distended but supple. The tumour has diminished astonishingly, and can be made out at level of the umbilicus, while the leg is

obviously reduced in size. October 8th.—The improvement so far is maintained.

*Hypodermic Injections of Soap Solution.*—For some years Mr. J. H. Webb, Melbourne, has been successfully treating cases of inoperable cancer by hypodermic injections of soap solution. When this fact came under my notice the first difficulty I had to encounter was that of determining the requisite strength of the solution and dosage. Unable to ascertain that the treatment had been tried by others I communicated with Mr. Webb. Meanwhile, Colonel Ligertwood and I agreed to commence with 5 minims of a 1 per cent. solution obtained from Messrs. Allen and Hanbury, increasing by 5 minims on alternate days to full dose of 60 minims every fourth day.

*Technique.*—The injections are given into the subcutaneous tissues. They were given chiefly into the outer surface of the upper part of either arm alternately or of chest in the neighbourhood of the growth. They were not altogether free from some smarting or pain, which, however, soon passes off or is obviated by previous injection of eucaine. They appeared to be more painful in the leg and in certain situations which vary individually, and which I have also noticed with other injections. Locally, the effect seems to vary from some tenderness to painful inflammatory areolæ and to lumps without suppuration. The soap solution readily passes through an ordinary fine steel needle, and the same details of syringe antiseptics and local anæsthesia before insertion of needle, are followed as previously noted in chian turpentine injections. For convenience, Messrs. Allen and Hanbury have put up for me one drachm doses of the sterilised soap solution in small stoppered bottles. These only require to be warmed before use and the solution poured into the barrel of the syringe.

The notes of cases treated by the foregoing method will be detailed elsewhere, with a fuller description of Mr. Webb's work and treatment. Amelioration was obtained in *all* of them, chiefly in the direction of decrease of tumour, diminution of foetor and discharge, and cessation of pain. The results obtained are such as to justify the hope that further experience may perhaps enable us one day to control malignant growths by hypodermic medication.

*Summary.*—From the experience I have so far gained, I am satisfied that the treatment is worthy of trial. The effects as shown in the cases recorded are diminution in the growth and removal of pain and foetor, followed by some restoration to normal nutrition as shown in the improvement in the general health of the patient. So far, these remarks apply to chian turpentine. With regard to Mr. Webb's treatment I am able to state that my experience so far with it has been attended with similar results, and the removal of some of the worst features—pain and foetor—confirms results claimed by him for this method of treatment. One case, independently testified to, is that of so far apparent cure of recurrent breast cancer, with hepatic metastasis and ascites. In neither case is it possible to assert what the precise action is of chian turpentine on the one hand or of soap on the other; and—whether Mr. Webb is right or wrong in his theory—in neither case could it have any influence on the gratifying results which have so far been gained by these methods of treatment. Despite the fact that an

extended trial is necessary in order to arrive at a definite conclusion as to the value of this plan of treatment, nevertheless I am personally satisfied that the results justify its trial in all cases of inoperable disease, and the urgency of cases of inoperable cancer has prompted me to publish these results of hypodermic medication, in order that no time may be lost in enabling others to put the treatment to a test themselves.

## THE WORK OF THE GENERAL MEDICAL COUNCIL.

G. CRICHTON, M.D.

"WHAT'S in a name?" There is not in truth a "General Medical Council." In 1858 the Medical Act was passed establishing the "General Council of Medical Education and Registration." In subsequent Medical Acts this title is carefully adhered to. The only place in the official Register where the words "General Medical Council" appear is on the page heading of the treasurer's report—evidently a proof-reader's mistake.

The primary object of the Council was to form a Register of educated and capable men, and unless a man were registered he was not to practise. The object of the Act was the public safety, "That persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners." Those whom the Council registered were (1) the possessors of a diploma from a college, or (2) of a degree of a university, or (3) such as had obtained some kind of an education and had begun practice on their own account, or (4) those who were surgeons in the Army or Navy, apparently without any diploma. For the future, those only were to be registered who held a diploma or a degree, obtained after examination following on a prescribed course of education. This, and the preparation of the Pharmacopœia, were the sole concerns of the General Council at the first, and no succeeding Act has enlarged either its functions or its powers. As the test of qualification was examination, so the Council represented examining bodies rather than education. It was a council of examiners, and so it substantially remains. Every diploma-granting (*i.e.*, examining) corporation or university sent one member (some were grouped and sent half a member). They sent examiners and teachers, and do now. Not every-day doctors, competing with quacks and patent medicines, struggling with clubs, the prey of the dishonest in all ranks, and of out-patient departments and dispensaries. Even the Crown members, who might have been a leaven, have always been Court physicians and surgeons. It was, and even now is, a body of schoolmasters, and with the common failing—one would not say fault—of schoolmasters, they expect too much from their pupils; examinations tend to become more and more oppressive.

In the first half of the nineteenth century qualification for any licence was held to consist more in "walking the hospital" than in passing examinations. In preparation for the new registration, 1,000 men passed Edinburgh College of Surgeons in one year. The percentage of failures is not stated! The third class, mentioned above, who underwent some period of study and who, as pupil or assistant, picked up some knowledge of the art, but who, not having taken a licence, and, in consequence, were ineligible for registration,

lingered on for many years as the unqualified assistant. It is only a few years since, not without some unavoidable harshness, he was definitely extinguished. The examination in 1857 of the College of Surgeons of England appears to have consisted of one final—in anatomy, physiology, pathology, and surgery. A good knowledge of the bones was essential, but admittedly a man might be very ignorant of the other subjects. The examination was oral and lasted an hour, a quarter being given to each subject.

If we take up the story twenty or twenty-five years later the whole face of things is changed. One college vies with another in the severity of its examinations, and the universities strive to out-do them. The subjects for the curriculum are by this time settled, the Register is under the care of one official, a satisfactory Pharmacopœia is in constant use. Yet anyone casually glancing at the medical journals about the year 1882 would hardly accept that statement as correct, for there is a loud demand for reform. There has been scarcely a year in which reform of the Medical Council has not been advocated. But in 1882 and onward a determined effort was made by the British Medical Association. The demand for district representation was passed. A better system of education, a uniform standard of examination, were urgently needed, it was said. The representatives of the corporations stood in the way of advance. If general practitioners are represented in the Council all these reforms will immediately ensue. From about this time dates the change of name, so that, in ordinary speech, it is now called the "General Medical Council." This shows a change in the popular mode of thought. It was assumed that the Council—reformed—although the reform concerned only the mode in which its members were to be elected, would be the protector and the guardian of the general practitioner.

A Royal Commission was appointed in April, 1881, and it reported on June 26th, 1882. On April 5th of the following year a Bill was introduced into the House of Lords. Its main features were a uniform State examination for all students, the number of members to be eighteen (afterwards seventeen), and four of these to be direct representatives. This Bill passed the Lords, but was blocked in the Commons. However, in 1886, the present Act was brought in by Sir Lyon Playfair. Instead of one State examination were conjoint examinations, and five direct representatives on a body of about thirty. The object, functions, and name of the General Council were unchanged. It had to do with education, so that men and women may be fitted to be on the Register, as being well qualified to treat disease: nothing more. Matters of great public concern: The incidence of enteric during war, the health of young adults in crowded towns, or of professional importance; the favouritism and nepotism and corruption of public medical appointments, or fees to medical witnesses or from clubs, and so on: these are matters with which the Council has nothing to do. They only touch occasionally the fringe of such a question when it may be supposed to relate to "conduct infamous in a professional aspect."

The effect of "direct representation" has been undoubtedly beneficial, though indirectly so. There have resulted: (1) A fairly uniform, yet diverse system of examinations, complete as to the various subjects; surgery, medicine, and mid-

wifery, which formerly were the subjects of separate diplomas; (2) a comprehensive scheme of education with an enormous amount of practical work; and (3) a constant interest, though *ultra vires*, shown by the Council, thus reinforced in medical matters generally, both as regards the public and the profession. In addition, the question of preliminary education, which had been the subject of discussion from the first, was settled. But the settlement, after all, came from without. The schools, by their leaving, and the universities by their *matriculation examinations*, definitely fixed the amount of knowledge essential to a student entering on the study of every profession. Yet no one can doubt that the repeated discussions of the Medical Council were of the utmost value in pointing towards such a settlement. The Council chamber was indeed almost the only arena where the matter—of extreme national importance—could be freely and fully debated.

Look back over these forty-five years. The work which the General Council of Medical Education and Registration was established to perform is accomplished. There will still be examinations to visit, a Pharmacopœia to edit, an occasional defaulter to deal with. A great task has been nobly accomplished. The beneficial results will prove more lasting than brass. "But (as Plato says) since everything that has come into being must one day perish, even a system like ours will not endure for all time, but must suffer dissolution."

## THE IRISH POOR-LAW MEDICAL SERVICE. (a)

By MICHAEL MCHUGH, M.D., L.R.C.S.I.,  
Visiting Physician to St. Vincent's Hospital.

FOLLOWING the established custom on occasions such as this, I propose to take advantage of the opportunity to draw attention to what is undoubtedly the most important question affecting the medical profession in this country. I allude to the very unsatisfactory state of the Poor-law Medical Service. Public expressions of opinion on this subject have no doubt been not infrequent during the past few years, but I feel nevertheless that no apology is necessary for again drawing public attention to it. The chronic state of discontent which the dispensary medical officers have constantly exhibited, and which I shall endeavour to show is exceedingly well founded, has lately entered upon an acute stage and matters have become so critical that at one time we seemed to have come within measurable distance of a general strike of the Poor-law medical officers, a body comprising 50 per cent., roughly speaking, of the whole medical profession in Ireland.

The present dispensary system in Ireland may be said to have come into existence in 1851, when attention having been forcibly drawn to the condition of the poorer classes owing to the appalling catastrophe of the years 1847-48, the Medical Charities Act was passed. By it the Poor-law Commissioners, acting through the local boards of guardians, were authorised to divide up the whole of Ireland into dispensary districts "with due regard to the extent and population of the districts," and to employ a medical officer for the care of the sick poor in each of these divisions. Prior to the passing of this Act, although the workhouses had been in existence since 1841, the only provision for the medical treatment of the outside poor was by provident dispensaries, few and far between, supported by private subscription and helped at times by grants-in-aid from county funds. So few and isolated, however, were these dispensaries, that in the County Mayo.

(a) Introductory address delivered at the opening of the Winter Session at St. Vincent's Hospital, Dublin.

in 1836, only one of them had been established in a district measuring 72 miles by 58.

The dispensary districts formed as the result of the Act of 1851 would seem to have been parcelled out without regard to any proper system or geographical method. Wherever a provident dispensary existed on a landlord's estate it was apparently taken over as a going concern and constituted the centre of a dispensary district, whilst the intervening irregular spaces were subdivided into new dispensary districts, without any apparent regard to the convenience of the peasant, and certainly not to that of the doctor in the discharge of his duties. These districts extended and still extend in extraordinary manners, interlocked with one another in hopeless confusion, enclosing lakes, mountains, and bog areas in such a way as to render the giving of aid to the mass of the people a matter of great physical difficulty, apart altogether from the question of adequate remuneration to the medical officer.

This institution of the dispensary district and doctor, defective as it was, nevertheless marked a great improvement on previous conditions, being, on the whole, a fairly successful effort to place medical aid within reach of the poor in all rural districts; but it is important to note that, inasmuch as it placed in every outlying portion of the country a State-aided medical man, the landlord and well-to-do classes gained correspondingly and probably even more than did the masses of the people. It brought to their doors a trained medical man available for their own needs, and who otherwise would not be there, whilst the State paid him a grant in-aid. This is a consideration which, I think, should be strongly emphasised, inasmuch as it shows that it is more in the interest of the general public even than of the medical profession that the Poor-law appointments should be held not only by competent men but by the best men procurable, and consequently that this important service should be made as attractive as possible to the rising members of the profession. The desirability of this policy will be rendered even still more evident when it is remembered that the Poor-law officer is also the medical officer of health of his district, so that in this most important matter of general sanitation the well-being of the public is entirely in his hands.

As a rule, whenever a Government has to deal with the medical profession, it endeavours to wring a full and exhaustive service from the unlucky doctor. By the Act of 1851 the dispensary medical officer was bound "without further fee or reward to vaccinate all persons in his district." He was also bound to certify all dangerous lunatics, to act as sanitary officer, to visit the local Bridewell, and all without extra pay. It requires years of struggle to get these duties disentangled from the ordinary dispensary medical work, and to be paid for separately. Gradually, however, this was done and now the duties of vaccinator, registrar of births and deaths, and the others just mentioned form separate items of the doctor's duties, and are paid for separately, though it may be stated that as in other matters in making these extra payments the very strictest economy is observed.

In other respects, it may be stated generally that the status of the dispensary doctor has remained unchanged since 1851, although since that period the medical curriculum has been lengthened from three to five years, and the difficulty of entering the profession, both as regards expense, extension of studies, and severity of examinations, has been more than doubled. Fewer young men are studying for the profession and fewer qualify. Furthermore, the Army and Navy medical services have lately increased the already high inducements which they hold out to junior qualified men, whilst the action of the General Medical Council in causing the dismissal of unqualified assistants to the number of 800 in England has greatly increased the demand in that country for young practitioners—a demand which must be largely supplied by the products of the Irish schools of medicine. I have already

pointed out how desirable it is, not only in the interests of the poor but also of all the inhabitants of a given district, that an efficient and competent medical officer should be provided, and it will be evident, I think, from the foregoing that the local authorities will have, as time passes, greater difficulty in doing so. They have to compete with other public services which have adopted a levelling-up attitude, and if they are to do so with any prospect of success, they and the Government must remove the undoubted and serious grievances of which the Poor-law medical officers have to complain.

The first of these grievances is, that the salaries paid to these medical officers are far from adequate and no reasonable recompense for their arduous duties. In order to demonstrate this, I shall again avail myself of the valuable store of information collected by Surgeon-General Evatt, and made public by him in the exhaustive report which he has furnished to the *British Medical Journal*. In order to give a clear idea of the amount of work devolving on the doctor and of the entirely disproportionate remuneration given him, Dr. Evatt selects for detailed description what he describes as a typical union in a typical county. The union selected is the Antrim Union, of the County Antrim. It contains six dispensary divisions which, according to Dr. Evatt, are very arbitrary divisions, often ridiculous in shape and without logical geographical boundaries. They grew up haphazard after the famine and have never been fully and systematically considered.

The first of these districts examined is the Antrim dispensary district. This division contains twenty-one miles of territory, and a population of 5,356 persons, the area being, however, below the average for all Ireland, which is forty-two square miles. For this district there is but one medical officer, without the assistance of either compounder, midwife, or district nurse. This medical officer, in the year 1902, saw at the dispensary 648 new cases, many of which had no doubt to be treated repeatedly. He also performed the duties of dispenser, making up with his own hands all the medicines required, and kept the many statistical records. He attended at the dispensary twice weekly, and also acted as registrar of births, marriages, and deaths, receiving one shilling an entry for births and sixpence for marriages. He attended at their own far-scattered homes over this twenty-one square miles 321 fresh and separate cases of illness, cases so serious as to be unable to attend at the dispensary for outdoor treatment, and of which many, no doubt, required frequent visits, and for those he also made up the medicine at the dispensary.

For these duties the medical officer drew the magnificent stipend of £100 a year from the guardians, one-half of which was paid by the State from the central fund for reducing local taxation. He was obliged, however, to keep a horse and trap and a servant. Now the officers of the Royal Irish Constabulary have a fixed allowance for a horse, £50 a year, and for a manservant, £45 a year. If we calculate the upkeep of the trap and harness for the year at £5 we discover that this medical philanthropist did this onerous and exhausting work and received actually no wages for his labours, his pay being but equal to the expenses of locomotion.

Dr. Evatt also analyses the conditions existing in the five other dispensary districts of the Antrim Union, a very similar state of things being revealed in each case, the principal difference being that although the districts might be larger the salary was generally lower. In the case of one then, in fact, the Crumlin district, though the area amounted to thirty-five square miles, the salary was £84 19s. 9d.

Comment on such a state of affairs is surely needless. Bad as it is, however, it may be said that worse remains behind. As has been just mentioned, the average area of the dispensary districts throughout the country is given in the Local Government official statements as forty-two square miles. Of a total of twenty-two

districts in County Clare, ten have an area of fifty or more square miles, the Corofin district has an area of ninety-five, and Ballyvaughan actually one of 110 square miles. All of these dispensary districts are in the sole charge of one medical officer, though several of them contain supplementary out-dispensaries (as many as three or four of these in some cases), although they have to be attended on stated days by the same officer. In the County Mayo there are no less than seven dispensary districts of over 100 square miles in area, all, again, in the charge of a single doctor, with a salary of £100, or perhaps a little more, and rising in only one instance to £150.

It is important for obvious reasons to bear in mind the huge size of some of the Irish districts as the area affects the questions of time and expense of locomotion consumed by the doctor in visiting his patients. In many of the larger districts a second horse would be required. Happily, as Dr. Evatt has pointed out, we have a clear official ruling as to the cost of maintenance of a horse. It is laid down in official documents to be seen at the head office of the Royal Irish Constabulary. According to them the annual sum allowed for the horse is £50, and for a servant £45 to cover food and pay, adding expenses for repairs. Dr. Evatt concludes we arrive at a sum which may be considered sufficient to at once wipe out all salary for purely professional work in a majority of the Irish dispensaries, the officers of which may be therefore be said to be doing their work gratuitously.

The argument of the official governing body is no doubt that the medical officers have their private practice, and that for their public duties only a portion of their time is required. In reply to this, it may be said that when we consider the size of the districts and the obviously large amount of dispensary work done by the doctors, a very much larger amount of work is done by them than is contemplated in their salaries. Furthermore, the constant exacting orders issued to them by the Local Government Board, requisitions for reports, on drugs and other matters, make considerable inroads on their time, leaving them little leisure for private practice. Again, it must be remembered that Ireland does not possess for the most part a middle-class capable of paying for medical attendance at its market value, nor a resident annuitant class able to pay a medical man a reasonable fee. And, finally, that the abuse of the system of issuing red tickets—the historic red tickets—deprives the medical officer in very many cases of his due by requiring him to attend gratuitously persons who might reasonably be expected to be able to pay. This latter has been a long-standing grievance with the medical officers, about which much has been written and spoken. There can be no doubt as to its reality, and the simplest way of removing it, and perhaps the only solution of the difficulty, is that the power to issue red tickets shall be limited to the relieving officers.

One of the most crying scandals in connection with the administration of the Poor-law Medical Service is the absence of any settled system of retirement and retiring allowances. There is no compulsory rule granting the medical officers superannuation, no matter how long may have been their services. And, furthermore, should any superannuation be granted by the local guardians, the charge falls entirely on the local rates, though during the whole term of service of the particular officer the State paid 50 per cent. of his salary. It would be difficult to find a more glaring anomaly. The whole cost of superannuation has been thrown on the local rates, and deliberately, by special Act of Parliament, for it has been enacted that though the local board of guardians may grant superannuation with the consent of the Local Government Board, the Act contains this special proviso, that "no contribution shall be made thereto out of any moneys voted by Parliament."

Will it be believed that there is also a rule in existence which ordains that no applicant for superannuation shall have his claim for superannuation even considered

until he has actually resigned his appointment? If it were not so unjust and tyrannical it would almost appear comic. What it really amounts to is this—that after a medical officer has devoted his life and abilities to the service of the sick poor he is himself placed upon the rates and becomes the recipient practically of outdoor relief, for it is in the power of the guardians, after he has resigned his appointment, either to grant or withhold an allowance.

There are other matters, such as the granting of leave of absence, either in case of illness or for the annual holiday, or for the purposes of scientific study, which might be considered with advantage on this occasion, were it not that the limitations of time preclude me from doing so.

In conclusion, I can only advert with gratification to the fact that the claims of the Poor-law officers have of late been actively pushed and advocated, and this time by an organised body—the Irish Medical Association. This Association has made the following demands on their behalf, *viz.* :—

1. That a minimum salary of £200 per annum shall be paid to each dispensary officer.

2. That a grant of one month's holiday annually shall be made in each case, with pay for the locum tenens at the rate of £4 4s. weekly; and

3. That suitable superannuation shall be granted as a right and not as a favour.

These demands are certainly legitimate; if they are at all it is on the side of moderation, and I feel confident that the Association in putting them forward will have the support of all independent members of the profession, and of all right-thinking men among the general public. It certainly has my advocacy, and I shall esteem myself fortunate if, in directing public attention to this important question, I have helped in any way to mitigate the hardships and to ameliorate the lot of that long-suffering official, of that friend of the poor, of that good fellow, the Irish dispensary doctor.

## THE VALUE OF LABORATORY WORK IN MEDICINE. (a)

By E. WAYMOUTH REID, B.A. Cantab., M.B. F.R.S.

Dean of the Faculty of Medicine, St. Andrews University.

In his opening remarks Prof. Reid said he wished to indicate some of the services rendered to mankind by those who devoted themselves to biological experimentation. Until this method was adopted for the solution of biological problems, the ideas of the processes going on in even the simplest structures of a living thing were distinctly bizarre, so that the great healing art had no true foundation. A capital instance of that fact was to be found in connection with the organ known as the pancreas. Vesalius was content to think that it was a general support to the parts around. Landanus did not doubt it expurgated those impurities of the blood too gross to be dealt with by the ordinary organs, while Wharton said it ministered to the nerves by taking up certain of their superfluities. For nearly 200 years no one had a ghost of an idea of the true use of this structure. Then came experimental inquiry, largely at the hands of Claude Bernard, and the "general support" of Vesalius, the "cleanser" of Landanus, and the "nerve soother" of Wharton was found to be the most important organ of digestion they possessed. Not long ago, as the result of a different class of experiments, came the great discovery of an entirely different and additional function of the same organ, which no method could possibly have yielded but experimentation, and which immediately shed light on their knowledge of a terrible disease. Gall had for his time a very accurate knowledge of the structure of the brain and actually observed that loss of the power of speech

(a) Abstract of the Introductory Address at the Winter Session of University College, Dundee.



occurred after injury to a certain part of the brain. The result of his deductions was his phrenology, which lived no longer except for the foolish who would pay a shilling for a pennyworth of flattery.

**THE THYROID GLAND.**—In his own student days the lecturer on physiology told them what the thyroid gland looked like under the microscope, but that was all. A London physician, however, observed that one of the concomitants of a terrible disease was the wasting away of this structure, and it was proved by experiment that the cause of the disease was the absence of the function of this organ. The cure followed in a few years. Graftings were made, the gland material was injected under the skin, and it was found that the result was the same when the gland material was eaten by the patient. The direct result was that not only was the growth of body and mind in a certain class of otherwise hopelessly imbecile children restored, but thick-witted adults, drifting into idiocy, could again enjoy their health. But the consequences of that most vigorous department of biological experimentation, experimental pathology, were perhaps of greater interest to a general audience. Ever since the great discovery of the relationship of certain diseases to parasitic micro-organisms, and of the poisons which they brewed, this morbid physiology had attracted so many ardent students that it was now a distinct branch of knowledge. The modern treatment of wounds, consumption, diphtheria, and tetanus, and of a host of other infectious diseases was the immediate result of the laboratory zeal of the experimental pathologist. The benefits which these results had conferred, and would yet confer, upon man and animals must strike every thoughtful person who would take the trouble to master a little detail. Much of the remarkable and ever-increasing services rendered by the experimental pathologist had directly originated from his study of the conditions of experimental or artificially-produced immunity to disease in animals, and in the course of his work he had introduced them to one of the most remarkable reactions of the organism, namely, the production of what were called anti-bodies, in response to certain stimuli.

**THE IMMUNITY PROBLEM.**—This immunity problem was certainly just now without a rival in its interest to the experimental biologist. It had been clearly proved that not only power of defence could be increased, but that it could also be conferred, if absent, by Nature. The normal blood serum (blood fluid) held a number of different protective substances in small amounts, and the experimenter had discovered how to increase the amount of one of these enormously. Physiology had often stood still for want of chemical assistance, and in this great immunity problem it was beginning to be quite clear that the chemist must step in if only to save them from explanations of every newly-discovered phenomenon by the assumption of the existence of a new substance. To the biologist the discovery and study of anti-bodies was yielding the idea of specificity of cells undreamed of before. But if enough was known for practical purposes, as prophylactic and curative results indicated, of the action of anti-bodies, it could not be said that the deeper problem of the machinery of their production by the organism was yet far on the way to solution.

Professor Reid then referred to the application, from a medico-legal standpoint, of the specificity of anti-bodies in discovering whether a given quantity of blood belonged to a man or to another animal. In concluding, he said real progress must be slow, and shifting sands of working hypotheses would shift and shift again ere the bedrock upon which to build was reached.

**Royal College of Surgeons in Ireland Fellowship Examination.**

DR. R. M. SMYTH, Assistant Superintendent, Natal Government Hospital, Durban, South Africa, having passed the necessary examination, has been admitted a Fellow of the College. j

## Clinical Records.

### SIR PATRICK DUN'S HOSPITAL.

*Case of Perforated Gastric Ulcer Simulating Appendicitis.—Operation Twenty Hours Afterwards.—Recovery.*

By C. ARTHUR BALL, M.D.,

Assistant Surgeon, Sir Patrick Dun's Hospital, Dublin.

**PATIENT**, a girl, *æt.* 22, was admitted into Sir Patrick Dun's Hospital on Friday, June 9th. On admission she was considerably collapsed, but went to sleep shortly afterwards and slept for some hours; she then woke complaining of very severe pain in the abdomen. I saw her shortly after 6 p.m. She stated that she had been ill since the previous Saturday, suffering from severe pains in the lower part of the abdomen, but was able to keep at her work (a domestic servant) until Thursday evening, about 10.30, when the violent pain began, most severe in the right iliac region; this had continued ever since. On Friday she was given a hypodermic injection, and sent into hospital by Dr. Wright, in a cab from Dalkey. She had not vomited at any time during her illness, and had eaten her usual food; her bowels had moved the previous day.

**On examination.**—The patient was evidently very ill; pulse 120 and weak; temperature, 101°; she occasionally hiccoughed; the facial expression was one of a severe intra-abdominal lesion; the abdomen was distended; the muscles over the lower part were rigid; the maximum pain and tenderness was over the iliac regions, most marked on the right side; a small, acutely tender superficial area was noticed in the epigastric region; liver dulness was present. The patient was obviously suffering from acute general peritonitis, and on questioning, stated that she had never had pain after food, and had never vomited. It appeared from her history that she had probably been suffering from appendicitis since Saturday, and that an abscess in connection with the appendix had burst into the general peritoneal cavity.

I operated immediately, first making a small incision in the middle line below the umbilicus, to explore the pelvis and see if it contained pus. On opening the abdomen no free gas was noticed, but turbid fluid, free from smell, welled up into the wound; the intestines in the pelvis were inflamed, but not very acutely. The pelvic viscera were explored without finding anything to account for the trouble. An incision was then made over the appendix. It was found very long, running up behind the cæcum, with a kink in it, and two or three old adhesions; in fact, it looked like a typical "interval appendix" but was only inflamed to the same extent as the surrounding intestines, and evidently was not responsible for the peritonitis present. An incision was now made in the middle line above the umbilicus; the transverse colon was adherent to the anterior abdominal wall, and completely covered with lymph exudate; the adhesions were easily broken down and the stomach examined. A perforation was found on the anterior surface of the lesser curvature near the cardiac orifice, about one centimetre in diameter, very patent, and through which fluid poured. The induration around the perforation was so extensive that excision of the area was impossible, and sutures, passed even some distance from the perforation, cut out as soon as tied. A fold of healthy stomach wall was therefore brought over the diseased area, and sutured to the gastro-hepatic omentum, which was indurated and friable for some distance away from the stomach. This, while effectually sealing the perforation, produced a good deal of deformity; however, fluid and flatus could be easily passed from one end of the stomach to the other. The cleansing of the peritoneum was then proceeded with; the peritonitis in the upper half was much more severe than that met with in the lower part of the abdomen; the viscera in the neighbourhood of the stomach were covered with lymph

and adherent to one another. These adhesions separated easily, and the whole abdominal cavity was washed out with large quantities of saline solution, until the fluid came away quite clear.

I then considered the advisability of performing a gastro-enterostomy as recommended by Mayo Robson. It would have been very difficult, owing to the thickened and inflamed condition of the intestines and stomach, and the patient's condition was such that any prolongation of the operation unless necessary to save her life was inexpedient.

Rubber drainage-tubes were passed to the renal fossæ and into the pelvis; the upper incision was left open and packed with gauze down to the perforation; the two lower wounds were completely closed, with the exception of where the tube entered the pelvis.

The after-history of the case was uneventful; the pulse and temperature gradually fell to normal. Convalescence was prolonged by the development, some two weeks after the operation, of an abscess in the upper wound due to the *Bacillus coli communis*.

Closely questioning the patient afterwards, she admitted having suffered from indigestion last Christmas year, which lasted till the following May. She had a slight recurrence of this last Christmas. She also gives a history of two attacks of pain in the right iliac fossa which may have been appendicitis.

She left hospital on July 18th, perfectly well, the alteration in the contour of her stomach apparently causing no trouble.

The following points in the case are of interest:—

1. Twenty hours had elapsed between the perforation and the operation, during which time the patient underwent the journey of nine miles, from Dalkey, sitting in a cab, a trying ordeal which she could hardly have borne without the morphia which, by masking symptoms, was to some extent responsible for the delay in having recourse to operation.

2. As has occasionally occurred, the history and symptoms pointed to appendicitis.

3. Vomiting was absent both before and after the operation.

## Transactions of Societies.

### WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

#### NOTES ON PSYCHOLOGY.

At the opening meeting of the twenty-third session of the above Society, held at the West London Hospital, on Friday, October 7th, the President, Charles M. Tuke, Esq., M.R.C.S., occupied the chair, and delivered an address on Psychology.

The President very naturally chose the special work to which he has devoted his life for the subject matter of his address. He referred to the able address of the late President, in which he dealt with the enormous advance made in medical knowledge during the last fifty years. But, striking and real as that advance undoubtedly was, it might be asked if the *treatment of insanity* had also advanced during that time. He replied that progress had been made in that branch of medical science almost as great as in any other direction—an advance not perhaps marked by any one great discovery, but chiefly by the general adoption of a principle which had been of enormous value to thousands, and had conferred honour on those who initiated it, and also on the whole profession of medicine. This system—the non-restraint system—is now universal, but in considering the advances of medical science, its first recognition must mark an epoch, and it is almost impossible to believe that its general adoption dates from only some sixty years ago. By very interesting references to ancient history and quotations from Plato, Euripides, Hippocrates, Coelius and Galen, &c., he compared the treatment of insanity among the ancients with more modern methods, and drew attention to the surprising fact that it is not possible to trace a gradual improvement in the history of the treatment of insanity—the same story of deplorable

ignorance: neglect, cruelty, and even imprisonment in chains and burning obtaining almost universally—until the close of the eighteenth century. It was not until 1792 that the name of Pinel recalls a noble change in the whole system, fifty-three patients being liberated from chains by him in that year at Bicêtre, and the non-restraint system inaugurated in France. In England, in the same year, William Tuke founded an institution in York called the Retreat, which was conducted on lines almost identical with the non-restraint system, and it is to William Tuke and his grandson, Samuel Tuke, that so much of the credit is due in obtaining the appointment of a committee of the House of Commons in 1815 to inquire into the condition and management of asylums. From that time dates the disappearance of ignorance and cruelty, and the rise of a high standard of moral management, also the building of new asylums superintended by men of intelligence, sympathy and humanity. Lincoln Asylum (under Mr. Gardner Hill and Dr. Charlesworth) and, on a larger scale, Hanwell Asylum (under Dr. Conolly) were very conspicuous examples of the new treatment. In dealing with the laws regarding the insane, Mr. Tuke emphasised the strides made in the right direction by the Vagrant Act in 1744, and also the noble work done by Lord Ashley (afterwards Lord Shaftesbury), through whose efforts the Commissioners in Lunacy were appointed. In the 58th Report of the Commissioners the number of persons certified as insane in England and Wales on January 1st, 1904, was 117,199, a return which showed a slight annual increase at a greater rate than the growth of the population. But this increase was more apparent than real; it was almost wholly among the pauper patients, and could perhaps be accounted for by the fact that cases are now more readily recognised and certified than formerly, and also because with the improved sanitation and medical treatment, aged cases are accumulating in asylums. The provisions of the law regarding both "Chancery patients" and the "voluntary boarder" were clearly explained, and the lunacy law was shown to be very ample, both for the patient and his property. Mr. Tuke gave valuable and practical advice as to the treatment of the so-called "nerve cases," and spoke in the highest praise of borough and county asylums—their one fault, if any, being that they had become too huge. Could the medical superintendent, however skilful and able, keep in medical touch and give individual attention to 2,000 cases, or even 1,000? After dealing with the causes and classifications of insanity, Mr. Tuke concluded a very interesting and able address by strongly advocating the need of public education, for great strides as the science of psychology had made, still further progress and more successful results would follow when the public were educated to realise fully that temperance, sobriety, and chastity were the essentials of Christian civilised communities.

### THE SOCIETY OF MEDICAL OFFICERS OF HEALTH.

The annual dinner of this Society was held at the Trocadero Restaurant last Friday. The chair was taken by the President, Dr. J. F. J. Sykes, and among the company present were Dr. Pye Smith, Dr. Groves, Sir T. Stephenson, Mr. Andrew Clark, Dr. Tatham, Alderman T. Idris, Dr. Whitelegge, C.B., Mr. Courthope-Munro, Dr. Parsons, Dr. Beaton, Mr. T. Cutler, Dr. Shirley Murphy, and Dr. Priestley. Dr. Whitelegge, proposing "The Municipal Authorities," said no public authority could afford to make a mistake in the selection and the support of their medical officers of health; and he was glad to think that municipal authorities were alive to this, and were offering inducements to men of the highest qualifications to engage in public work. Alderman T. Idris (Mayor of St. Pancras) responded. Dr. Pye Smith proposed "The Incorporated Society of Medical Officers of Health." He said the connection of the medical profession with preventive medicine was of the most honourable and

satisfactory kind. Investigation into zymotic diseases had thrown a bright light on methods of preventing disease and of curing and relieving them. He was proud of the public spirit, the unselfish devotion, the courage in opposing vested interests and indifference medical officers of health had displayed. It was due to their persistent efforts through generations that this country had taken the lead in improvements that had made it one of the most healthy in the world. Dr. Sykes, in returning thanks, congratulated the members on the fact that they now numbered 937, and the main body of these were acting medical officers of health. He held it to be essential that in the course of their duties they should make themselves acquainted with some branches of architectural construction, for in these days the tendency was to pack the populations of towns in a manner that was injurious to public health and led to that physical deterioration of which so much was heard. In all classes of society there was this tendency to overcrowd, and the medical profession should join hands with architects and agree among themselves as to the limits of aggregation of population. Mr. Andrew Clark, replying to the toast of "Kindred Societies," proposed by Dr. Groves, said the British Medical Association were endeavouring to forward a Bill in Parliament to get rid of the insecurity of tenure of office of which medical officers complained, and he hoped that during the coming Session that Bill would become law and medical officers would no longer be under liability to removal from office in consequence of doing what they considered to be their public duty.

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, October 16th, 1904.

#### TREATMENT OF LUMBAGO.

In the neuralgic form, the following wafers, according to Dr. Capitan, are very successful:—

Phenacetin, gr. iv ;  
Acetanilide, gr. j ;  
Antipyrin, gr. vj ;  
Salophane, gr. v ;  
Bromide of potassium, gr. iv.

For one wafer ; three daily.

When the patient is of a gouty family, five grains of salicylate of lithine might be added.

In the myalgic forms, pyramidon acts well. However, it must be given in somewhat large doses, from twenty to thirty grains a day. The urine will become red, and give a large deposit of urates. The patient should be watched and the largest dose reached only progressively.

Certain patients derive considerable benefit from the association of antipyrine with salicylate of soda:—

Antipyrine, dr. j ;  
Salicylate of soda, dr. j ;  
Water, oz. ij.

Four or five teaspoonfuls daily.

In every case of lumbago, and in addition to one or other of the above remedies, ten grains of hydrochlorate of quinine should be given morning and evening.

The local treatment should not be neglected. A good liniment is as follows:—

Salicylate of methyl, dr. ij ;  
Tincture of belladonna, dr. ij ;  
Laudanum, dr. ij ;  
Spirits of camphor, oz. iv.

Where the pain is clearly localised, excellent results can be obtained from subcutaneous injections of antipyrine:—

Antipyrine, dr. j ;  
Hydrochlorate of cocaine, grs. v ;  
Water, dr. iij.

Massage, graduated movements, and warm baths terminate the treatment.

TREATMENT OF TINEA TONSURANS BY PROF. GAUCHER.

*Children.*—Cut the hair as close as possible once a week. Every two days wash the head with soap and warm water. Morning and evening, massage the scalp, triturating the diseased spots energetically. After the massage, prolonged friction by means of a tooth-brush with the following liniment:—

Spirits of camphor, oz. iv ;  
Castor oil, dr. j ;  
Tincture of cantharides, dr. j.

*Adults.*—Not necessary to cut the hair, which offers the advantage of masking the spots. The head will be washed once a week with tar soap. Repeated and frequent massage will be done by the patient or someone else in the family. Every evening friction with:—

Eau de Cologne, oz. iss ;  
Spirits of lavender, oz. iss ;  
Tincture of capsicum, dr. j.

The following ointment might be substituted for the above liquid preparations:—

Peruvia<sup>l</sup> balsam, grs. xx ;  
Salicylic acid, grs. xx ;  
Resorcin, grs. xx ;  
Lanoline, oz. iss ;  
Vaseline, oz. iss.

At the same time the patient will be recommended to rub the head every morning with the following slightly stimulant mixture:—

Essence of turpentine, oz. ss ;  
Spirits of camphor, oz. iij ;  
Liquid ammonia, dr. j.

Or in the case of a woman:—

Corrosive sublimate, grs. iv ;  
Glacial acetic acid, min. xx ;  
Resorcin, dr. ss ;  
Hydrate of chloral, dr. j ;  
Tincture of cantharides, dr. j ;  
Tincture of jaborandi, dr. j ;  
Proof spirit, oz. viij ;  
Castor oil, oz. j ;  
Ess. of violets, q.s.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 16th, 1904.

In the *Allgemeine medizinische Zeitblatt-Zeitung*, 17, 1904, Dr. Enis reports a case of

HERPES\_ZOSTER OF A RECURRING, INTERMITTENT OR PERIODIC TYPE.

The patient first came under treatment during a free interval, and complained of paræsthetic symptoms in the left half of the mouth. Examination of the cavity revealed nothing abnormal. The writer prescribed quinine, but without effect ; then nine drops daily of Fowler's solution, again without effect ; later on, pills of ergot and quinine bromide were ordered. In six months 120 pills had been taken. Thirty pills were taken during a period of treatment, then they were stopped for a longer or shorter period, and then begun with again. This time there was no recurrence, and the paræsthetic symptoms disappeared. Further observation of the case might possibly have shown how much of the improvement was due to the treatment and how much to a more favourable season of the year, the disease generally recurring at cold seasons and getting better during the warmer ones ; but the patient was lost sight of through change of residence.

At the Medical Society, Hr. Glucksmann spoke on

**ŒSOPHAGOSCOPY: ITS AIMS, ADVANCES, AND VALUE.**

He thought it was a pity that œsophagoscopy was practised by so few. The reason for this neglect lay in some difficulties that could be easily overcome, and in not being able at the very first to recognise what became visible.

The first to see into the human œsophagus was Kussmaul, who examined the sword swallower in 1868. The first œsophagoscope was constructed by Mikulicz, and several others had effected improvements on it. Œsophagoscopy was not intended to displace the other methods of examining the parts, such as by the sound, but to aid them. By it, carcinoma of the gullet could be diagnosed when sounding failed to discover it, although there had been difficulties of swallowing, and stenosis from caustics had been rendered visible when the sound had passed through it. On the other hand, symptoms had been seen to be due to spasm only when everything had pointed to carcinoma.

It had a therapeutical value when, in a case of stenosis, it permitted the passing of a filiform bougie by visual aid. In all conditions of softening the speaker held the œsophagoscope to be more sparing than the sound, as the latter must pass the contracted part in order to discover it, whilst the former allowed it to be seen from above.

In speaking of the future of œsophagoscopy, he said that since the introduction of the method of operating in rarefied air a new future had been opened to surgery, both of the thorax and of the œsophagus; the œsophagoscope would be called in to facilitate early diagnosis of disease of the œsophagus. He also considered œsophagoscopy to be a step in the direction of gastroscopy. The present methods of gastroscopy were not practicable ones; they were too dangerous, and the stomach resented the introduction of instruments.

Hr. Elsner was of opinion that systematic washing and cleansing of the œsophagus would often render the disagreeable employment of the œsophagoscope unnecessary. By this means he had gradually dilated a very narrow stricture in a boy. In the case of malignant stenosis also the œsophagus could often be kept free for a long time in this way.

Hr. Boas did not think œsophagoscopy of much practical value. The early diagnosis of malignant disease was not much furthered by it, neither would gastroscopy help much in the diagnosis of cancer of the stomach. Kelling, among others, had shown that gastroscopy could diagnose cancer of the stomach early enough for a radical operation to be carried out, but that did not indicate any great advance.

At the Dermatological Society,

**EPITHELIAL CANCER**

was discussed. Hr. Unna recommended the use of the Röntgen rays. Hr. O. Petersen (St. Petersburg) would treat rather expectantly in the early stages before the glands became implicated. He would use continuous soda solutions, the Finsen, Röntgen, or radium treatment, and freezing, but more especially the Finsen treatment. The dosage of radium was still uncertain, and sometimes long-lasting irritations were set up. No cure had resulted from freezing, although improvement had taken place. A case of v. Bergmann's that had been cured was shown by Dr. Schlesinger. He preferred operation: the results of surgery might be ideal if the public could be taught to bring the cases early. So much time, too, was spent in Röntgen treatment that it was too late for operation. The Röntgen rays were less active the deeper they penetrated, and deep action was the chief aim of all cancer treatment. Inoperable cases might be submitted to

Röntgen treatment. If this was energetic enough it certainly had a curative effect.

V. Marschalko had cured an ulcerated tumour the size of an apple in a woman, æt. 77, in four weeks, and in eight months there had been no recurrence. Lesser (Berlin) had quite satisfied himself that rodent ulcer could be cured by Röntgen treatment. Deep carcinomata belonged to the knife and not to Röntgen treatment. Holzkneckt said the future belonged to radium. Kiel was of opinion that if, out of ten cases nine could be cured by Röntgen treatment, and all by surgical procedures, it was the duty of the surgeon to cure all, even if a cicatrix was certain to be left, and the same with rodent ulcer. Petrini had had good results from the combined methods.

**Austria.**

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 16th, 1904.

**ALCOHOLIC TREATMENT OF ERYSIPELAS.**

At the Prague meeting, Walko spoke in high praise of the treatment of erysipelas by means of alcoholic compression in the form of bandages applied to the part affected with wadding or gauze well saturated with a 96 per cent. solution of alcohol. He considers the "Alcoholcellit" prepared by Dieterich an excellent form of applying the alcohol to the part. This preparation is in the form of a jelly, containing 60 per cent. of alcohol, and protected from evaporation by being packed in lead cases which are air-tight. When needed the case is opened and the jelly spread over the affected part with a spatula. Over this is placed a layer of Billroth's "battist," or impermeable cambric, and the whole supported by a bandage. By this means the alcohol is given off slowly and remains long in contact with the part to which it is applied, and continues active for twelve or twenty-four hours. Another firm prepares a gauze with this "Alcoholcellit" under the name of "Duralcolbinden," which is reputed to contain 96 per cent. of alcohol.

Neustadtl said he had obtained excellent results from alcoholic applications in osteo-periostitis and tuberculous tendo-vaginitis. He spoke highly of it in the treatment of tuberculous lymphadenitis and chronic arthritis.

**SPASMUS NUTANS.**

Raudnitz showed the meeting a child to support his theory of nystagmus being caused by confining children to dark rooms. In addition to the nystagmus there was a vibratory shaking of the head. He related how he had kept five dogs four months in a dark kennel, all of which acquired nystagmus and two of them shaking of the head—one of which he produced as interesting.

One month was sufficient in some to produce the nystagmus. These facts, he thought, were potent enough to establish his theory that dark rooms and gloomy neighbourhoods were sufficient to produce spasmus nutans.

Ganghofer was of opinion that there was some truth in Raudnitz' theory, as the greater number of cases he had met with were drawn from dark dwellings, but he had also received them from faultlessly clear, bright homes, where light was abundant.

Fischl could not understand how these experiments of Raudnitz proved anything, far less the theory he endeavoured to propound for the origin of spasmus nutans, because children when very young had the eyes closed, and as they grew older they turned their

eyes to the light no matter how imperfect. In all dwellings there are either doors or windows that admit of a certain amount of light, which would be open for the child to exercise its vision, and therefore in a different position to dogs entirely excluded from light for months. Children in dark rooms instinctively turn their eyes towards any gleam of light, therefore the analogy fails when these experiments are compared.

#### ECHINOCOCCUS HEPATICUS.

Springer showed a child, *æt.* 12, on whom he had performed laparotomy for echinococcus of the liver. By this operation he attached the cystic portion to the wall of the abdomen and after six days had elapsed he opened the cyst and cleared out the sac, which afterwards healed up favourably and left the patient healthy and well.

#### PERITONEAL TUBERCULOSIS.

Thönes gave an analysis of 80 cases which he had treated according to Kummel and Braun's method, operating for tubercle in the peritoneum. He thought the whole question lay between puncture and laparotomy, but the latter, in his opinion, was the most effectual where operation was indicated. If the disease be active, as in phthisis, the operation should be deferred, but where exudation and adhesions are present, laparotomy should be performed, as prolonged internal treatment gives very doubtful results. In the discussion Hippel reported three cases of ileo-cæcal tuberculosis on which he had operated, but all of them died subsequently of anal fistula. He believed this was due to the separation of adhesions in the bowel affected. He is now persuaded that this part of the bowel should have been resected after separating the adhesions.

#### TREATMENT AFTER PURULENT PERITONITIS AND FATTY NECROSIS.

Bertelsmann described the history and dangers of profuse peritonitis followed by collapse due to the empty condition of the heart. To overcome this difficulty he intravenously injects three and a half litres of salt infusion and increases it according to Heinecke's theory to twenty litres in the following days. In a case of fatty necrosis of the peritoneum, this form of treatment was a perfect success.

Oppenheimer discussed the different forms of pulse that required this treatment, and the difference of temperature that existed in peritoneal affections: between the temperature in the axilla and the temperature of the anus. The greater the difference of these two temperatures the more gloomy was the prognosis. Haberer thought that many of these cases with diffuse effusions died not from the relaxation of the heart but toxæmia. In such cases he could not see where salt solutions when injected into the blood could be of much service.

Rehn was of opinion that death was usually accomplished by bacteriæmia and not by toxæmia.

## The Operating Theatres.

### ST. MARK'S HOSPITAL FOR FISTULA.

#### LAPAROTOMY—PECULIAR CONDITION OF THE VISCERA.

—MR. SWINFORD EDWARDS operated on a Russian, *æt.* 57, who had had trouble with his rectum (as it was reported) for fifteen years. On examination of the passage he was found to have a contracted anus, and above this, as far as the finger could reach, the rectum was stenosed, thickened and firmly attached to the surrounding tissues. The sensation communicated to the explorer's finger was as if the pelvis was filled with new growth, but no typical cylindroma could be

detected within the rectum. For this condition Mr. Edwards proposed a left iliac colotomy. The abdominal wall was opened in the left iliac region by splitting the various muscular layers in the direction of their fibres. On opening the abdominal cavity no trace of the sigmoid flexure could be discovered. There were hard masses and nodules to be felt in various portions of the mesentery. Believing that this was a case of malposition of the sigmoid, Mr. Edwards repeated the operation in the right iliac fossa, and here the colon was found, indurated and firmly fixed to the iliac fossa and to the posterior lumbar region. The appendices epiploicæ were likewise indurated and contained separate nodules. The whole of the large intestine to be felt through this incision gave a sensation to the finger as though the parts had been hardened in formalin. Colotomy here seemed impossible, and as there were no acute symptoms of obstruction the operator postponed attempting to open possibly the transverse colon until a later date. Both incisions were closed by suturing first with silk the peritoneum, secondly the muscles, and thirdly the skin and aponeurosis, the last with silkworm-gut. Mr. Edwards said that the pathology of the case was wrapped in obscurity, as against the theory of carcinoma was the long period over which the disease had extended; nor was it an ordinary example of columnar-celled carcinoma of the bowel. Against it being tuberculous was the fact of the density of the induration and the small amount of purulent discharge. The history of the case was somewhat obscured, as the patient was unable to speak a word of English, and only two or three words of German. The operator remarked that he had before come across two cases of misplaced sigmoid colon, that it is to say when this portion of the intestine passes across the abdomen to the right side, lying over the caput coli before turning over the brim of the pelvis. In both of these the sigmoid was opened, colotomy being performed in the right iliac fossa. In the present case, Mr. Edwards was unable to determine whether the large intestine discovered in the right iliac fossa was the sigmoid or the commencement of the large intestine, owing to the parts being so indurated and firmly bound down. It would, he thought, be interesting to know what the subsequent course of the case may be, and what the microscope may show. He suggested that it might be an infiltrating form of carcinoma engrafted on old-standing tuberculous disease, although he had never met with a like case.

OPERATION FOR ANAL TUMOUR.—The same surgeon operated on an old woman, *æt.* about 65, who had had pain and rectal discharge for some months past. There was an external orifice of a fistula in the right posterior quadrant; corresponding with this, about an inch and a half up the bowel, was a large internal orifice surrounded by a considerable mass of what felt like granulation tissue; between the internal and external orifices the induration was considerable, forming a tumour the size of a small hen's egg. Mr. Edwards mentioned that the patient had been admitted for rectal cancer, but he, mistrusting this diagnosis, determined to lay the parts open as when operating for ordinary fistula in order to examine the cut surface of the tumour, and subsequently to proceed as the exigencies of the case seemed to demand. The patient

having been placed on her right side, a probe-pointed director was passed through the fistulous tract, and the probe point brought out at the anus. The intervening tissues were then divided and the cut surface of the tumour exposed to view. It presented a peculiar glistening appearance, and reminded one of grains of boiled sago. The surface of each section measured about one and a half inch by one inch. Mr. Edwards excised both portions of the growth for microscopical examination. After this the wound presented the ordinary appearance of a wound after operation for a deep fistula. Mr. Edwards remarked that in this case the rectal condition gave a sensation to the examining finger as of an ordinary rectal carcinoma, accompanied by a small fistula, but against the malignant theory was, in the first place, the position of the growth, which was situated in the right side of the bowel, just within the external sphincter. Cylindrical-celled epithelioma, he said, usually attacked the bowel somewhat higher up, and when of the nature of squamous-celled epithelioma it usually started about the junction of the skin and mucous membrane, involving first the anal outlet, which the growth under consideration did not; moreover, there was a fistulous track running right through the tumour, which was, to say the least, very uncommon in rectal cancer. Pain, too, was marked by its absence, which, he thought, would not have been the case in rectal carcinoma so low down. From all these considerations Mr. Edwards was inclined to look upon it as some curious form of inflammatory induration, on the exact nature of which he hoped light would be thrown after an examination of the removed growth.

#### ROYAL EAR HOSPITAL.

**OPERATION FOR NASAL OBSTRUCTION.**—Mr. YEARSLEY operated on a woman, *æt.* 45, who complained of complete obstruction on the right side of the nose, with constant colds in the head, severe frontal headache radiating from the root of the nose, and paroxysmal attacks of sneezing. There was loss of smell, occasional deafness, and the patient was quite unable to breathe adequately through the nose. The complete obstruction had lasted since an attack of pneumonia in the winter of 1903, although before that she was often slightly stuffy in the nose, and prone to catch cold. On examination, the septum nasi was seen to be much deviated to the right; the concavity on the left side being occupied by a greatly enlarged middle turbinal body; the right middle turbinal could be partly seen behind the deviated septum and extended downwards into the inferior meatus. Digital examination revealed a large pad of adenoids in the naso-pharynx. The patient having been chloroformed and the nose sprayed with 1 in 1,000 adrenalin solution, the left middle turbinal was removed by cutting through its attachment to the outer wall of the nose with scissors, until a small neck of bone was left. As it was difficult to pass a snare wire round the turbinal, the neck of bone was broken through with Doyen's forceps. The septum was next partly sawn through with a nasal saw and straightened by means of septum forceps, thus enabling the operator to reach the hypertrophied left middle turbinal, which was taken away by means of scissors and snare. Finally, a large pad of adenoids was removed with Kirstein's curette. Mr. Yearsley said that the case illustrated the result of the effect on the nose of the neglect of adenoids. It was quite true that the

symptoms of adenoids often abated at or about puberty, but this was as often due to the enlargement of the post-nasal space as to the disappearance of the adenoids themselves. In this case probably the nasal condition was largely owing to the frequent acute catarrhs induced by the adenoids. Obstruction from enlarged middle turbinals was very common; these bodies frequently become what are practically large bony cysts from chronic inflammatory processes. Owing to the fact that the course taken by the inspired air is a parabola, the highest part of which reaches to about the centre of the middle meatus, any enlargement of the middle turbinal naturally causes obstruction to nasal breathing. The pressure of enlarged middle turbinals upon the septum is a frequent cause of nasal headache; such headaches are very characteristic and often very severe. They commence at the root of the nose and radiate upwards over the frontal region. In such cases removal of the middle turbinals quickly results in the disappearance of this distressing symptom.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, OCTOBER 19, 1904.

#### L'ENTENTE CORDIALE—“AU REVOIR.”

THE French “medical caravan” has departed after three days of strenuous labour. Their hours were counted, and each had its allotted task—if the word may also be made to include sundry festivities, public and private, that formed large on the programme. We are fain to confess that our visitors showed themselves indefatigable. If they did not inspect every one of our large general hospitals in detail, if some of them snatched a fearful joy by visiting the Wallace Collection or the National Gallery instead of being conducted round Colney Hatch or the University laboratories, the majority rallied to the bugle-call of duty and fell into the ranks at the appointed hour. While we are too experienced to be rendered vain by the admiration so freely bestowed on our medical and scientific monuments, much of which, no doubt, was mere



politeness, we certainly retain the impression that our visitors took away with them ideas and impressions that may, in their eager hands and fertile brains, influence current views in France. Nothing, perhaps, impressed the more discriminating of our visitors so much as the colossal results obtained in this country by individual and collective effort in the provision of hospital and laboratory accommodation, a contrast to the absolute dependence of similar institutions on the State elsewhere. In commenting on this fact it is in no wise our intention to compare the one method with the other, for each has its peculiar advantages and its inherent drawbacks. Centralisation no doubt makes for economy of administration, but it is destructive of individual initiative; independence of State control confers plasticity upon the organisation, but paves the way to abuses of its own. The difference is seen in the ample floor space allotted to each bed in English hospitals. This is rendered possible by the fact that, being a private institution, conducted in accordance with rule, no patient is accepted in excess of the available accommodation. The French hospital, on the contrary, is a municipal institution, and as such is obliged to admit applicants even though their reception necessitates more or less overcrowding of the wards. Foreigners look with undisguised admiration tinged with envy at the *claires silhouettes des nurses charmantes*, whose presence gives a brightness and suavity to otherwise depressing surroundings. The gaily decorated children's wards, the ample provision of toys and flowers, the general air of comfort and almost happiness that pervades them, touched them to the quick, and the sincerity of their appreciation was apparent. We venture to think that they were not less surprised and pleased—we are speaking of those who only knew the English as painted by French tradition—to find what a genial host is masked by the external austerity of the typical Englishman. Certainly the effort made to entertain our guests rose to the occasion, and nothing, absolutely nothing, was left undone to make their visit both agreeable and instructive. It would, of course, be easy to find fault with the programme, and some would reproach the organisers with having attempted too much, others with having achieved too little, but, in truth, the organisers acted in deference to the maxim that *qui trop embrasse mal étreint*. As it was, the individual members of the band were enabled to choose their intellectual pabulum and direct their steps accordingly. One of the most charming features of the visit was the spontaneity and enthusiasm with which the medical practitioners of the Metropolis threw themselves into the work. Beginning with the tactful visit of Sir William Broadbent and several distinguished colleagues to the station to receive the guests and guide them to their quarters, the same pleasant foresight enveloped them throughout, and each vied with the other in the endeavour to make the reception worthy of the occasion. The King himself took cognisance of the

terminal banquet on Wednesday evening, and with the graceful courtesy that endears him to his people, expressed the interest he took in this incident of the *entente cordiale*. The banquet was literally and figuratively a "huge success," upwards of four hundred convives of the two nationalities being sandwiched at the endless array of tables. The *cuisine* was worthy of the Hotel Cecil, and the post-prandial oratory attained the giddiest heights of French eloquence. A touch of humour was provided by the entertainers speaking French and the guests English. We were peculiarly fortunate in being honoured with the presence of Professor Poirier, whose reputation as an orator is now firmly established north of the Channel. The sober eloquence of Professor Chauffard, M. Lucas-Championnière and Dr. Huchard testified to the qualities of lucidity and harmony that stamp the great French clinical lecturers and confer a charm on their utterances. Receptions of this magnitude cannot, of course, be every-day occurrences. We hope, however, that our French *confrères* will take this one to mean that they are always welcome in our schools, that we entertain feelings of sincere regard and affection for them, and that we look forward to working with them, hand in hand, for the relief of suffering and the greatness of humanity.

#### TWO THOUSAND OPERATIONS FOR APPENDICITIS.

"EVERYTHING," said John Bright, "that can be said on the subject of education has been said hundreds of times over," and the same is almost true of appendicitis. But with that disease continually confronting him, and the question of the right moment of surgical interference still a matter of opinion, the practitioner may derive advantage from the experience of a surgeon like Mr. John B. Murphy, who has two thousand operations for appendicitis to his credit. In the *American Journal of Medical Sciences* for August, Mr. Murphy analyses these cases, their symptoms and course, and gives his opinion on the treatment of the condition in decided words. In dealing with the pathogenesis of appendicitis he mentions having found foreign bodies in 2 per cent. of his cases, a proportion that is higher than is generally supposed to prevail over here, whilst in no less than 38 per cent. faecal concretions were present. Bacteriological examination was diligently pursued, and in order of frequency, he noted *Bacillus coli communis*, *Staphylococcus pyogenes aureus* and *albus*, streptococcus, pneumococcus, *Bacillus tuberculosis* and actinomycosis as the predominating organisms. With regard to the semeiology, Murphy is very emphatic in the importance of pain as the initial symptom of an attack; in the whole of his cases it was the first fact in the illness. Indeed, when vomiting or pyrexia precedes the abdominal pain, he disbelieves the diagnosis, and if the patient's temperature has been raised for a day or two before the onset of pain, he generally suspects typhoid fever. The pain of appen-

dicitis is usually colicky in character, and reaches its maximum intensity in about four hours, when in the majority of cases it begins to subside. Although pain, in his opinion, is invariably the primary symptom, he is equally sure that fever always occurs, sooner or later, in a genuine case, and these two signs, combined with vomiting and tenderness in the right iliac region, and perhaps the whole abdomen, constitute the important features of the onset of an attack. The character of the pulse is of little help, and leucocytosis is of no value beyond showing that absorption of septic products is taking place; indeed, it is not always present, even when pus has formed. After describing the modes by which appendicitis may terminate, either by resolution or by abscess-formation and further infection, Murphy proceeds to describe some of the less common sequelæ that he has met with, two of the most interesting being portal thrombosis and thrombo-phlebitis of the iliac veins with general embolism. Writing from the standpoint of a surgeon, and a very distinguished surgeon too, it is natural that purely medical treatment should find but small favour at Mr. Murphy's hands, and one reads without surprise that every death from appendicitis is due to not calling in a physician early enough, or to the dilatoriness of the physician or surgeon when he is called in. It is all very well for the physician to make an early and accurate diagnosis, but he is not justified in deferring operation because the final results in appendicitis are, on the whole, favourable, whilst the surgeon, on his side, must not run the risk of doing a primary radical operation when an inflammatory condition is present, but rather defer it to a later period. The man who is having more than three or four deaths in a hundred operations is either receiving the patronage of incompetent and procrastinating men, or he is doing too much manipulation in the peritoneal cavity under unfavourable pathological conditions. Such, at least, are Mr. Murphy's views. He then illustrates from his own records the influence that current medical opinion has upon the mortality from the disease. He divides his operations into series of a hundred each and compares the fatality of the various groups. As would have been expected, the highest death-rate, 11 per cent., occurred in the first group, and the lowest, 2 per cent., in the last. With regard to the latter, we may say that, considering that operative cases of all sorts are included in it, and that each of the two deaths were due to causes not directly connected with appendicitis, the result is one reflecting the greatest credit both on the operator and on the practitioners who sought his assistance. He points out, however, that the mortality in his earlier groups fell steadily till 1896, when, at the meeting of the American Medical Association at Atlanta, a great deal of feeling was expressed against frequent abdominal operations, especially those for appendicitis. He traces to this cause the fact that the mortality of his next hundred cases rose to seven, as general

practitioners hesitated before advising operation. This prejudice gradually wore off till 1900, when again a movement in favour of conservatism set in—a state of opinion that found its reflection again in a rise in Murphy's operation fatality: this time to 6 per cent. On this side of the Atlantic there is still a general feeling that the mild cases of catarrhal appendicitis, in which the constitutional symptoms are slight, are best treated by the expectant method, the question of operation being reserved for the period of quiescence, and we do not think that even Mr. Murphy's far-reaching figures disprove the wisdom of this course. We certainly agree with him, however, that it is not safe to allow a patient who has had an attack of appendicitis to wait till another has taken place before considering the question of removal. Mr. Murphy's brilliant results in operations undertaken between attacks, only one death in thirteen hundred cases, should give courage to the most diffident.

### Notes on Current Topics.

#### The Hypodermic Medication in Cancer.

In another part of our present issue readers will find an interesting article by Dr. Shaw-Mackenzie on the treatment of inoperable cancer by hypodermic medication. Although the writer cannot claim any cases of cure, he has nevertheless obtained results of a distinctly encouraging nature, such as relief of pain and shrinkage of tumour-growth. Some granulomata, such of those of syphilis, become definitely absorbed under the influence of drugs introduced into the system. There is nothing on the face of it to show why a similar result may not be obtainable in the case of malignant neoplasms, provided the right drug and the right method of administration be ascertained. Dr. Shaw-Mackenzie has made the pioneer move in the necessary experimentation, and it is to be hoped that other investigators will follow in his footsteps. His full research is not published in the article that appears in the present number of THE MEDICAL PRESS AND CIRCULAR, but those who wish to study the matter in detail will find the opportunity in a pamphlet shortly to be published. Hypodermic medication forms one of many ways in which we may hope one day to solve the problem of how to cure cancer, a subject which still offers to the scientific enthusiast one of the greatest—perhaps the greatest—crowns awaiting the heroes of medicine.

#### Conservatism in Surgery.

THE Huxley Lecture delivered by Sir William MacEwen at the opening of the Winter Session of Charing Cross Hospital has received somewhat more public attention than is usually awarded to such pronouncements. This is in some degree due to the lecturer appearing more or less in the rôle of critic of current surgical practice, but perhaps still more to the fact that his address had to do with

the appendix cæci, an organ which looms very large in the mind of the public. There is perhaps little that is new in Sir William MacEwen's address, but there is much that has not been so well said by any other. He raises the voice of calm reason and common sense against the meddling interference of the tinkering surgeon. He believes that the normal healthy body is a more perfect organism than the maimed creature which would remain after the "improvements" some surgeons advise, even though nothing has been improved away but the apparently useless and functionless. There are many parts of the human anatomy whose function is as yet unknown, but we are far from justified in believing that they are useless. More particularly, Sir William MacEwen applies his argument to the case of the appendix and the cæcum, and though his observations are not complete, he brings forward cogent reasons for the opinion that both structures have very definite purposes to fulfil. He points out that in all herbivorous animals caecal digestion takes place to considerable amount, while in some it is more important than gastric digestion. The secretion of the glands of the cæcum and appendix is affected by the ingestion of food, and the fluid has in all probability a definite digestive value. But apart from any hypothesis as to the functions of the appendix, in the great majority of men it causes no trouble, and there is little justification for the removal of so innocent an organ. This caution against too radical surgery has been given by others before the Huxley Lecturer, but it gains much from his sound common sense as well as from his caustic wit.

#### A Short Way With Lunatics.

THE discussion started some months ago by the publication of a pamphlet recommending the sterilisation of degenerates has received a certain revival by Dr. Fred Smith's paper before the Forensic Section at the Oxford meeting of the British Medical Association. Though much more moderate, both in scope and expression, than the other paper, yet the plans proposed lie much in the same direction, and one cannot but think that Dr. Smith has been influenced by Dr. Rentoul. He takes a very pessimistic view as to the curability of lunacy in general, and he applies this view in particular to the case of the criminal insane. Assuming that the criminal lunatic is unlikely to be cured, why not place him beyond the power of repeating his crime? His execution is not to be regarded in any way as a "punishment," but merely as a safeguard, bearing in mind that he is a useless and probably harmful member of society. In the case of child-murder by mothers, usually a result of puerperal insanity, Dr. Smith thinks a recurrence of the crime can be adequately prevented by the performance of the operation of oöphorectomy, followed by a detention under observation for whatever period may be found necessary in each individual case. In the case of criminals whose insanity is due to alcoholism or

other drug habit, he advises castration, followed by conditional release, as a guard against the multiplication of degenerates. If, however, there should be the slightest lapse from teetotalism, the patient should be returned to the asylum. Excellent as these suggestions might be if we were starting to build up a brand new civilisation, we think they are hardly likely to have much effect on the present condition of European thought.

#### Overlying of Infants.

THOUGH all medical men in practice among the poor are frequently brought into contact with cases of overlain infants, it is doubtful if many are fully aware of the enormous mortality from this cause. In London especially, the number of children killed in this way is so alarming that it can best be realised by stating that the number of deaths from "suffocation in bed" during the past ten years is equal to that from typhoid fever, being little under two thousand each year. When it is remembered that these children are as likely as not to be quite healthy, one can gauge to some extent the loss the nation is sustaining. In most cases, too, it is probable that the deaths are the result of pure accident, though in some, drunkenness in the mother may be the principal cause. It is noticed that the greatest number of deaths from this cause occur on Saturday nights, when there is most probably a greater indulgence in drink than on other evenings of the week. On the other hand, Saturday is the busiest day of the week for most wives of working-men, so that they are inclined, although perfectly sober and temperate, to sleep most soundly on that night. Much good might be done in the way of prevention by the visitation of mothers by tactful female visitors who should advise the use of cots for young infants, and should dissuade from suckling in bed. Instruction on the subject might also be given to the girls in Board Schools, who should certainly receive regular teaching on the care of infants.

#### Treatment of Neuralgia by Injections of Air.

THE use of hypodermic injections of air to produce local anæsthesia is, of course, well known, but various French physicians have in recent times extended this principle to the treatment of obstinate neuralgias. Cordier, of Lyons, experimented on several cases of obstinate sciatic neuralgia, with very considerable success. In more than half the cases treated, one injection, varying in amount from a quarter to half a litre, gave permanent and complete relief, while in only two cases was there failure. Similarly, Mongour and Carles, of Bordeaux, were successful in the treatment of post-herpetic intercostal neuralgia, a complaint most obstinate to other methods of treatment. The mode of procedure is very simple. No apparatus is necessary beyond an ordinary Pravaz or Roux needle, which can be attached to any simple air-pump, such as a common bicycle-inflator, or a rubber bag. If it is thought necessary

to filter the air, a glass tube containing a cotton plug can be interposed between the pump and the needle. Air can be injected until the patient declares that the pain has disappeared. It will take some days for the gas to be absorbed, and until this occurs, the part should be gently stroked each day. Only one caution is necessary—to avoid a vein. The method has much clinical evidence in its favour and deserves a trial in this country.

#### Transplantation of the Urethra.

THE *Annals of Surgery* for last month contain an account of some ingenious attempts by Mr. J. H. Pringle, of the Royal Infirmary, Glasgow, to repair the urethra by substitution. Operations were performed on three different subjects, the urethras of young bullocks being used to replace the damaged or absent urethra in the patients. In one case, that of a boy with hypospadias, seven centimetres of urethra from a bullock were transplanted; but although the graft "took" well it was found impossible to effect union at the juncture of new urethra with the old, and finally the implanted tissue sloughed. The whole of it was excised, and a fresh graft, consisting of nine centimetres of bullock's urethra, was inserted in its place. After some trouble this became soundly incorporated with the living tissues, and the boy finally left the hospital well. He had, however, to pass a bougie to keep the canal patent. Of the other two patients, one was a man of fifty, who had an abscess of the penis that led to gangrene and sloughing of the urethra. After six weeks of supra-pubic and perineal drainage, Mr. Pringle endeavoured to provide him with a new urethra from a bullock; but though the graft grew well, a fistula remained at the junction with the old aperture in the urethra, and several attempts did not succeed in closing it. The third case was that of a young man whose perineal urethra was ruptured by an accident. The transplanted urethra became quickly joined to the surrounding tissues, but a tiny sinus remained in the perinæum. This seemed on the point of healing when, unfortunately, the patient died suddenly after an operation for abscess of the kidney. On the whole, the degree of success obtained by Mr. Pringle may well encourage him to continue using this original method.

#### The Studious Habit.

To few of the sciences does the aphorism that "knowledge is power" apply with so much force as that of medicine. The helplessness of ignorance is never so apparent as when the practitioner is face to face with a great pathological problem, the ins and outs of which are seemingly involved in hopeless obscurity. Some forms of disease will, of course, baffle the most learned at times, yet there are occasions when the veil is lifted as if by magic at the approach of superior wisdom. There is no road to the higher learning save by the narrow and arduous track of ceaseless study. In the busy days which make up the round of active profes-

sional life there remains a minute fraction of time in which the hard-pressed medical man may devote his spare energy—if there be any left—to the duty of keeping in touch with the latest work or, it may be, to the task of investigating for himself some of Nature's pathological secrets. Desultory reading may not appear fruitful, yet if once the necessity of continual self-culture be recognised, systematic habits of study will soon be formed. In this habit has lain the success of many who, but for the formation of the studious habit early in life, would have been condemned to a mediocre existence. The art of "redeeming the time" from this point of view has yet another advantage, which was dwelt on by the Bishop of Oxford in his opening address before the West London Post-Graduate College on October 13th, namely, that a provision for old age is thus laid up. When the body is past work and the easy chair becomes more of a necessity, the mind will perforce turn itself inwards, and happy is he to whom length of years forms no bar to the acquisition of knowledge, and whose study is veritably a mental haven of refuge.

#### Poisoning by Boric Acid.

SOME years ago, at the transition period between vigorous antiseptics and modern asepsis, it was the custom in surgery to make use of boric acid in large quantities. The general belief was that its absorption was quite harmless, and it was applied with the greatest freedom to raw surfaces and operation wounds. Though this custom is now happily nearly obsolete, yet there is still in some quarters a tendency to make use of the dry powder or of a solution in the treatment of abscess cavities, without much regard to the possibilities of free absorption. That such practice is not free from danger is shown by the fact that several deaths have been recorded from boric acid poisoning under exactly these circumstances. Dr. Charles Best, of Chicago, who reports the most recent case,<sup>(a)</sup> and collects particulars of four other fatal cases, points out that all of them resulted either from prolonged irrigation with saturated solution of boric acid, or packing of large cavities with the dry powder. The usual symptoms of severe boric poisoning are profuse vomiting, a papular rash over the face and chest, and a weak, irregular pulse. Post-mortem but little was discovered—some cloudy swelling or fatty degeneration of the hepatic and renal cells, and in one case small subpericardial hæmorrhages.

#### A Massage School.

THE word massage has in the past covered a multitude of sins, from gross quackery to barely-disguised immorality. So distasteful were the abuses accompanying its practice that for many years a number of medical men would have nothing to do either with massage or with masseurs. Even now it cannot be said that the art of massage is entirely in the right hands, or conducted in the

(a) *Journ. of the Amer. Med. Association*, September 17th, 1904.

right way, and we are glad to learn that a school for teaching massage in all its forms is about to be opened under the auspices of the National Hospital for the Paralysed and Epileptic, Queen Square. Practitioners ought to be able to judge of the ability of a masseur or a masseuse to carry out his directions, and the minimum that can be accepted as evidence is the possession of a diploma from some respectable institution framed on right lines. The private teachers who profess to give instruction at present are by no means always persons of recognised status or skill, and their "course" hardly carries conviction of competency with it. The Committee of Queen Square have an admirable opportunity, and may be expected to place the matter in a satisfactory position. It is disappointing to learn that their course of instruction is to last three months only. Considering the high fees that masseurs can earn, and the complexity that the art is acquiring, a year would be none too long to require of their students. When a nurse after three years' training can look to making only two guineas a week, besides her board and lodging, it seems unfair that a masseuse after three months can be in a position to earn a pound or more a day for considerably less work. We hope it is not too late for the Committee to reconsider the matter, especially as Swedish movements are to be included in the curriculum.

#### The Value of Meat Extracts.

THE nitrogenous extractives of muscle are both numerous and complex. The relation of these substances to urea and uric acid was early demonstrated by chemical physiologists, and the identification of carnine acid with anti-peptone, announced by Siegfried and subsequently confirmed by Blake and Fraenkel, was an important contribution to our imperfect knowledge of the question of proteid constitution. From the practical aspect, however, it has been found that creatin, creatinine, xanthine, and allied bodies which are capable of being extracted from fresh meat have comparatively little food value. The use of the word "extract" in this connection is somewhat unfortunate, since to the average individual the word is apt to indicate the concentrated essence of all that is nourishing in meat. All meat extracts are popularly supposed to be very strengthening, and any statement to the contrary is met with incredulity. Even good home-made beef-tea, that mystic concentration of fleshy strength, does not deserve the high opinion which is usually placed upon it, but it may be safely asserted that the best infusion of beef contains very little assimilable proteid, its virtue consisting entirely in the stimulating property possessed by the numerous extractives dissolved therein. The relative merits of meat extracts and beef-tea have been exercising the minds of the Holborn Board of Guardians. One of the medical officers of the Board had declared that "it was impossible to tell what animal it (meat extract) is made from and whether it had died from disease." There is much truth in this

statement, though we are glad to know that some well-known firms really do turn out wholesome products that are above suspicion. On the score of expense, beef-tea is preferable, and as a savoury stimulant there is nothing better in sickness or convalescence, and it is generally most acceptable to the patient.

#### Nurses for Middle-Class Homes.

WE are glad to note that a scheme is on foot for providing people of the middle-class with the services of a nurse in their own homes. As opinions on the subject have been requested, we may say with confidence that there is hardly a practitioner who would not welcome such an arrangement, provided it were properly organised and managed. As matters stand at present the poor in most parts of the country, and in nearly all the large towns, can have the benefit of a nurse's assistance in times of sickness through one or another of our existing philanthropic agencies. No such provision is made for the poorer middle-class. Without advocating that nursing by members of the family—which is certainly a duty, and should be a privilege—ought to be superseded in general, one knows that in many cases additional skilled help is needed in dressing wounds, giving nutrient enemata, and similar manipulations, and this among people of small means who do not wish to avail themselves of public charity. A nurse's fees, especially in long illnesses, are often beyond the resources of the smaller tradesmen and clerks, and with the raising of the standard of sick-nursing that is going on around us, no reduction of fees can be looked for. To place the services of a skilled nurse within the reach of such people would be a worthy and enlightened piece of philanthropy, and we hope that the scheme may be carried through successfully. It is proposed to give the nurses' services gratuitously; this, we think, would be a mistake. The working expenses of the institutions would fall entirely on the funds provided if this were so, and the scope of their operation would be proportionately curtailed. Charging small fees, whose amount was adapted to the patients' means, would not only relieve the income of the committee of a heavy burden, but would be acting on the higher principle of making people help themselves—as far as they are able.

#### The Hygiene of the Elevator.

A CONTEMPORARY has somewhat humorously suggested that a sound article might be written upon the subject of "The Lift, or Elevator, and its Influence on the Physique of Nations." Such a title might not commend itself to the writer of an M.D. thesis, as the number of pathological lesions resulting from the habitual use of the elevator is not great. It may, indeed, be urged by those who love to cavil against the application of hygienic tests to the affairs of daily life that were the lift little better than a death-trap it would hardly signify, seeing that the time spent in one by the average passenger is so short. The

attendant himself, however, would fare ill if such were the case. The view has been put forward, and it is even now held by some conservative folk, that the lift encourages habits of laziness, especially in the young, and that the older and more sensible method of stair-climbing is far more beneficial to the muscular system. Perhaps chlorosis and anæmia were not so common fifty years ago, but there is nothing like a good mount up six or eight flights of stairs to detect the slightest degree of cardiac incompetency accompanying these complaints, which are so frequently met with among our city youths and maidens. An individual suffering from organic disease of the heart would be sorely tried by climbing such heights, whereas by the use of the lift he is enabled to carry on his business without discomfort or increased risk. As a time-saving appliance the elevator has become an absolute necessity, for hurry is the order of the present age. From the surgical standpoint more might be done, perhaps, in the way of providing better safeguards at the entrance of lift-holes, as lamentable accidents not infrequently occur from neglect of such precautions. The ventilation of many elevators is far from perfect, and in busy establishments the lift-man or boy must suffer from the effects of breathing bad air.

#### The Central Midwives' Board and the Rotunda Hospital.

IN our present issue we publish a letter from the Master of the Rotunda Hospital, in which he informs us that the serious difference of opinion, between the Board and the hospital authorities, as to what constituted a properly trained nurse had been at last arranged to the mutual satisfaction of both parties. We are very glad that this is so, and desire to congratulate them on the fact. Common sense must have taught that it was a manifest impossibility to refuse to recognise nurses trained as are those at the Rotunda Hospital, and if the hospital authorities have found it possible to make the alterations suggested by the Board without interfering with the value of the hospital training for either nurses or students, it is well that they should do so. If the present training of the midwife is to be improved it can only be by the careful and intelligent supervision of a Board so instituted as to be suitable for its purpose, and by the loyal assistance of the training centres. If, however, the actions of the Board appear to be governed by prejudice and illogicity, it cannot complain if they are resisted by training centres which did not require reform. While we are referring to this subject, we desire to express our deep regret at the unexpected death of Mr. Heywood Johnstone, M.P., who was largely responsible for the creation of the Board. We have at times been compelled to disagree on different points with his policy on the question of the training of midwives, but that his actions were solely directed to the effecting of a very necessary improvement in the present class of midwife we are sure. It was, however, a pity that he did not allow himself to be

more guided by the advice of the profession which was best calculated to give such advice. Had he done so the piece of legislation with which his name will be always associated would have been more efficacious, and, we fancy, more permanent.

#### The Hygromed.

THE hygromed is a little instrument invented by Dr. Wetherill, of Philadelphia, or rather adapted by him from the spiral hygrometer, with the object of measuring accurately the degree of moisture of the skin in disease. Dr. Wetherill's first step after completing the construction of the instrument was to test its value and authenticity on normal folk, and it was not till he had made a thousand different observations, and ascertained the ranges of variations in health, that he began using the hygromed in disease. It is now ten years since he began work, and he thinks the results he has obtained show that there is a distinct, if limited, scope for his instrument in the examination of the sick. His most practical observations are those made in cases of renal disease, especially in threatening uræmia. He found that when a fall in the quantity of urine was compensated for by an increased transpiration of the skin, the patient's condition was not appreciably changed, but when in renal disease he found a progressive diminution in the dryness of the skin, the danger of uræmia was great. In œdema, the skin was shown to be possessed of less moisture than over parts that were not œdematous, and after hot baths, although perspiration was induced at the time, the moisture of the skin remained below normal for some days afterwards. In exophthalmic goitre cutaneous excretion of water was increased by 10 per cent., and in paralysis the skin was generally drier on the helpless than on the sound side. Many other interesting observations have been recorded of the condition of cutaneous excretion in fever and other conditions, and this clever little instrument may not unlikely soon find its way into the clinical apparatus of the physician.

#### The Therapeutical Society.

THE appearance of the second volume of the *Transactions* of the Therapeutical Society reminds us of the excellent objects of the founders. It bears testimony to the excellence of its work, namely, the desire to advance the knowledge of pharmacology and therapeutics, in the list of papers which have been read and discussed during the year 1903-04. The ground covered by the Society is of the widest, as may be gathered from the range of titles, which include an account of the aconites, the pharmacology of the saponins, the action of bodies in a particulate state, photography in natural colours, inguinal trusses, blood leucocytes, and so on. Variety is certainly to be found here for a wide diversity of therapeutical palates. The present president, Sir W. Thistleton-Dyer, will be succeeded by Sir Lauder Brunton. The popularity of the Society is attested by the rapidly-increasing roll of membership. During the past



year the number has been increased by no less than sixty-two Fellows, twenty-seven of whom are Corresponding Fellows living abroad. Further details of the Society can be obtained from the honorary secretary, Dr. T. E. B. Brown, Willesden Lane, London, N.W.

### Eye Massage.

WITH reference to the comments in our last issue upon "Eye Massage," we are assured by Dr. Ettles, of the Minorities, that he has not been nominated by Mr. Stephen Smith as his "referee," as stated in our article, nor is he in any way "connected with that gentleman or his hospital." This information was founded on statements in at least one London daily newspaper. We are glad, however, to publish this disavowal on the part of Dr. Ettles, and we regret that such misleading information appeared in a public newspaper. Dr. Ettles, moreover "is not an anti-vivisectionist, nor does he at all agree with Mr. Smith's method of correcting defects of vision by manipulation"; at the same time, we must clearly state that no such attitude was hinted at in our remarks.

### PERSONAL.

ACCOMPANIED by Queen Alexandra, the King has graciously consented to lay the foundation-stone of the new King's College Hospital to be erected at Denmark Hill, Camberwell, on a site presented by the Hon. W. D. F. Smith, M.P.

HIS MAJESTY THE KING has graciously consented to give his patronage to the Sanitary Institute, which was founded in 1876, and is carrying on a large work in teaching and examining in hygiene and sanitary science, and maintains in London a permanent museum of sanitary appliances.

LORD KELVIN will present the prizes at the St. George's Hospital Annual Distribution, on October 28th next.

SIR WILLIAM COLLINS, M.D., has been re-elected President of the Medico-Legal Society for the coming year.

SIR PATRICK MANSON, K.C.M.G., M.D., will deliver an address on the significance of fever in patients from warm climates at the autumn meeting of the West Somerset Association Branch, to be held at Taunton on November 4th.

SIR WILLIAM MULOCK recently embodied an amendment to the Post Office Act in the Canadian Parliament with the view of prohibiting the passage of quack advertisements through the post.

PROFESSOR W. R. SMITH is announced as Conservative and Unionist candidate for the representation in Parliament of the Glasgow and Aberdeen Universities. As the previously selected candidate, Sir Henry Craik, is still before the constituency, the path of the Liberal party seems likely to be somewhat cleared of obstacles if Dr. Smith persists in his candidature.

PROFESSOR KOCH, on his way to Africa, is at present paying a visit to Paris, where he has several times visited the Pasteur Institute and the Academy of Medicine.

At the Inauguration Ceremony of the University of Leeds the honorary degree of Doctor of Science

was conferred upon a number of distinguished scientific men, amongst whom were Sir Arthur Rucker, Sir T. E. Thorpe, the well-known chemist, and Professor L. C. Miall, the biologist.

THE honorary D.Sc. was conferred upon the following physicians and surgeons:—Sir William Broadbent, Mr. C. G. Wheelhouse, Mr. Jonathan Hutchinson, F.R.S., Mr. T. Pridgin Teale, Dr. John Hughlings Jackson, Mr. A. W. Mayo Robson, and Dr. Tempest Anderson, the ophthalmologist and authority on volcanoes.

DR. H. LESLIE ROBERTS has been appointed to the newly-created post of lecturer on dermatology in the University of Liverpool.

MR. C. CARTER BRAINE will take the chair at the annual dinner of the Society of Anaesthetists, to be held on October 21st, at the Hôtel Métropole, London.

MR. C. ST. AUBYN FARRER, Westbourne Park Road, London, W., will be pleased to hear from any medical men wishing to take part in the forthcoming inauguration of the Association of Medical Diplomates of Scotland.

SIR LAUDER BRUNTON, M.D., F.R.S., has just returned to London after his visit to the United States.

MR. JAMES CRAIG, F.R.C.P.I., Physician to the Meath Hospital, Dublin, and Registrar to the Royal College of Physicians, has been elected General Secretary of the Royal Academy of Medicine in Ireland.

It has been extensively rumoured during the past week that the post of President of the Queen's College, Cork, is to be filled by the appointment of Professor Reginald Windle, Professor of Anatomy in the University of Birmingham. It is probable that by the time we go to press this rumour will have been confirmed.

SURGEON-GENERAL EVATT has arrived in Ireland at the request of the Irish Medical Association. We understand that he proposes to hold a series of meetings through the country at which the present condition of the Poor-law Medical Service will be discussed, and that he has also been asked to assist at the reorganization of the Association itself.

## Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

### SCOTLAND.

PARLIAMENTARY REPRESENTATION OF GLASGOW AND ABERDEEN UNIVERSITIES.—The Universities of Glasgow and Aberdeen Conservative and Liberal Unionist Association have recently issued a circular recommending Professor W. R. Smith, M.D. Aberd., D.Sc. Ed., barrister-at-law and J.P. for the County of London, as a candidate for the vacancy which will arise at the next general election owing to the retirement of the Right Hon. J. A. Campbell, M.P. In making the selection the Association were influenced by the recommendations of a Committee, to whom they referred the subject—that the candidate should be a medical man, and that, if possible, he should be an Aberdeen graduate. The medical Faculties of the Universities have never hitherto been directly represented in Parliament, and for the past twenty-four years the member has been connected with the University of Glasgow, although a general understanding exists that nomination should be exercised alternately in favour of a graduate of each University. Apart from all questions of politics, we cannot but desire that the medical representatives in Parliament should be added to, especially when, as in the case of Professor Smith, the candidate is one who would so materially add weight to the votes of his professional brethren in St. Stephens.

Professor Smith has for the past fifteen years been Professor of Forensic Medicine and Director of the Laboratories of State Medicine at King's College. He has been medical officer of the London School Board, and medical officer of health for Woolwich. He has taken a prominent part in all matters concerning public health, has filled the office of President of the Royal Institute of Public Health, and is a member of the Metropolitan Asylums Board. It is unfortunate, however, that his candidature cannot be supported by the official party associations of the Universities, who have already a candidate in the field. From a communication which has appeared in the daily press it appears that the official associations of the two Universities met in the spring of this year and unanimously resolved to recommend to the constituency as its next member Sir Henry Craik, who is about to vacate the office of secretary to the Scottish Education Department. Under the circumstances the rivalry between the candidates is not one of politics, since both are Unionists, but consists in the fact that the original official candidate is apparently to be opposed by a non-official medical candidate. Both parties assert that they have considerable prospect of success. The outcome of the affair will be watched with interest; we note in the last clause of the London Association's circular that Professor Smith "has not at present signified his assent to become a candidate, and prefers not to do so until the general wishes of the graduates are known." It seems that very little, if anything, of Dr. Smith's candidature was known in Scotland until the circular was actually issued.

**CALEDONIAN MEDICAL SOCIETY.**—The greater part of the current number of the *Caledonian Medical Journal* is occupied by an account of the proceedings in connection with the annual meeting. The society now numbers 230 members, of whom 90 reside in Scotland, 107 in England, and 18 in "other" foreign countries, chiefly South Africa. The following office-bearers for the year 1905 were elected:—President, W. Stewart, M.D.; Vice-President, W. A. Mackintosh, M.D.; Secretary and Treasurer, S. R. Macphail, M.D.; Council, David Blair, M.D. George Gilson, M.D., John Keay, M.D., W. Murray Lester, M.D., Alex. McDonald, M.D., and Professor W. Japp-Sinclair. The chief feature of the meeting was an address by the retiring president, Dr. George Mackay, on "Ancient Gaelic Medical Manuscripts," in which it was suggested that the Caledonian Medical Society should consider it their duty to share in transcribing, translating and rendering intelligible to their contemporaries these interesting documents. The proceedings concluded by the annual dinner, held in the Caledonian Station Hotel.

**MEDICAL PRESENTATION.**—Dr. Andrew Graham, Currie, a well-known Midlothian practitioner, on the occasion of his semi-jubilee of practice in the district, was entertained at a dinner in the Craig Memorial Hall, Currie, on the 14th inst. Sir James Gilson Craig, who presided, presented Dr. Graham with an illuminated address, and a cheque for £100, and Mrs. Graham with a silver tea service and salver in the name of his numerous patients and friends in the district.

#### BELFAST.

**THE BELFAST GUARDIANS.**—The members of the Belfast Board of Guardians do not seem to be as gallant as is expected of Irishmen, for at their meeting last week, when they proceeded to appoint a resident medical officer, they rejected three lady applicants and appointed the one man who applied! The successful applicant, Dr. Patton, had been doing temporary duty in the workhouse, and came into the board-room in the usual white jacket, to which one of the guardians promptly took exception, saying the candidate should have appeared before them properly dressed. The chairman explained that this was the usual professional costume, but the worthy grocer refused to be comforted, and maintained that the doctor was not sufficiently respectful to his employers.

**THE NEW SANATORIUM.**—The Local Government

Board having sanctioned the purchase of the Abbey at Whitehouse as a Workhouse Sanatorium for Consumptives, arrangements are being made for the use of the same. It is proposed to accommodate twenty-five patients, as well as the administrative staff, in the house, and twenty-five patients more in new buildings in the grounds. It is also proposed to appoint a resident medical officer at £120 per annum, with rations and apartments, and a visiting medical officer to visit every day, at £150 per annum. Dr. Ritchie, a medical member of the board, objected to the proposed salaries as too high, but did not say at what figure he would rate the services of his professional brethren.

**THE DANGER OF NITRIC ACID.**—A case was heard at Lurgan Quarter Sessions last week in which a minor, by his mother, sued for £20 damages against a local chemist who he had consulted about warts on his hand. The chemist gave a small bottle of nitric acid, labelled "Poison," and told him to touch the head of the wart with the cork of the bottle. He did so, and suffered so much that the finger had to be amputated in the Lurgan Infirmary. His Honour held that the fact that the boy had been told to apply the acid with the end of the cork was sufficient warning to the mother to exercise due care in its use. He was sorry for the boy's sake that he was compelled to dismiss the case.

**NOTIFICATION OF INFECTIOUS DISEASES—TEST CASE.**—A case of some interest to medical men was heard at Newtownards Petty Sessions last week, when the Urban Council sued the mother of a child who had suffered from scarlatina for not notifying the case, and also sued Dr. Parke, the medical man in charge of the case, for not notifying it sufficiently promptly. The mother of the child was fined 10s. and 1s. 6d. costs, and the case against Dr. Parke was then taken. It appeared that the child was removed to hospital on Sunday, and that Dr. Parke sent in his note on Monday evening. The Act says that the case is to be notified "forthwith," and on the ground of his delay Dr. Parke was fined a similar amount to the mother of the child.

### Correspondence.

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

#### KING'S COLLEGE HOSPITAL AND ANTI-VIVISECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am sorry to find that a passage in the Address which I delivered at King's College on October 4th has given rise to some misapprehension, which I will ask you kindly to give me the opportunity of correcting. The passage in question is as follows:—"The laboratories of experimental pathology and also of neuropathology cannot conveniently be transferred to the new hospital, for the council and hospital staff are agreed that original researches in these subjects which may involve experiments on living animals shall find no place within its walls." In the scheme described in the address a strong dividing line is drawn between the "early" and the "advanced" studies. The former will be carried on at King's College in the Strand, the latter at the new hospital at Camberwell. But the subjects referred to in the passage clearly belong to "advanced" studies, and, therefore, might naturally be expected, under the scheme, to form part of the student's education at the hospital. They cannot, however, as I have said, be conveniently transferred to the hospital for the reason assigned. It appeared desirable, therefore, to call attention to what is an important exception to the general rule.

These studies have always been carried on in the laboratories at King's College, never in King's College Hospital, and there will be no change therefore in the existing arrangement. As regards experiments on living animals, such as inoculations, for diagnostic purposes, these have never been performed in King's College Hospital, but always in the appropriate laboratories at King's College. In view, however, of the

greatly increased distance between the hospital and King's College in the future it will obviously be necessary that provision should be made at the hospital for investigations of this nature.

There was not the slightest intention, in the passage to which you take exception, to imply any antagonism on the part of the council and medical staff to the employment of experiments on living animals.

I am, Sir, yours truly,

THOMAS BUZZARD.

Grosvenor Street, October 14th, 1904.

[Inoculations for diagnostic purposes, it is clear from the foregoing explanation, will in future be made at King's College Hospital. They are technically "vivisections," and therefore traverse the general inference from the passage quoted from the address.—ED.]

#### THE CENTRAL MIDWIVES BOARD.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In view of the attention that has been lately drawn to the proceedings of the Central Midwives' Board in connection with the status of Irish trained midwives to practise their profession in England, I take the opportunity through your columns to announce that the points at issue between this Board and the Governors of the Rotunda-Hospital have been amicably arranged.

The Central Midwives' Board have formally intimated their intention to ask the Privy Council to modify their rules so as to permit our hospital to be placed on the register of Institutions whose certificates will be accepted.

Our thanks are particularly due to you, Sir, for your able and untiring advocacy of the claims of Irish trained nurses to equal recognition with those educated in other parts of the United Kingdom.

I am, Sir, yours truly,

E. HASTINGS TWEEDY,

Master, Rotunda Hospital.

Dublin, Oct. 12th, 1904.

#### ALCOHOLISM AND INSANITY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—We may, I think, congratulate ourselves on the fact that Professor Clouston has taken up this matter of the relation of alcohol to insanity. The scientific aspects of the matter are still imperfectly understood; indeed, they amount to little more than well-informed and reasonable speculation. The advent of any candid, clear-headed, and specially equipped investigator is, therefore, to be hailed with delight by all interested in this great social problem, whose vital bearing it would be indeed hard to over-estimate. Speaking as a medical man, it has always seemed to me the main difficulty in approaching the question is that of separating cause from effect. Does the drunkard make the lunatic or the lunatic the drunkard? In other words, is the alcoholism causative or symptomatic? In any case, the evil of alcohol, as pointed out by Dr. Clouston, is preventable, and be the margin of this form of madness great or small, it should be done away with among a civilised and self-respecting community. But, then, so also should alcoholic cirrhosis of the liver and delirium tremens. The quality of the alcoholic drink is another factor of prime importance; bad liquor spells ruin to body and to mind. The way in which the humblest citizen may help his countrymen to rise to better things is by voting in favour of wise restrictive legislation upon the production and the distribution of alcoholic drink both as regards quality and quantity. It is to be hoped that the matter thus ably opened up by Dr. Clouston will be widely discussed by competent critics.

I am, Sir, yours truly,

DAVID WALSH.

Hanover Street, London, W.  
October 17th, 1904.

#### Obituary.

LIEUT.-COLONEL GEORGE RYAN, R.A.M.C.

THE death is announced at Ryde, Isle of Wight, of Lieutenant-Colonel George Ryan, late R.A.M.C., at the age of 59. He entered the Service in March, 1868, as Assistant-Surgeon, becoming Surgeon in 1873, Surgeon-Major in 1881, and Surgeon-Lieutenant-Colonel in 1889, when he retired. Lieutenant-Colonel Ryan served in the Zulu war of 1879. He took the L.R.C.S. and L.R.C.P. Edinburgh in 1867.

WILLIAM CHATTAWAY, F.I.C., F.C.S.

MR. WILLIAM CHATTAWAY, the superintendent of the Apothecaries' Hall, died on the 7th inst. at the age of 43, after undergoing an operation for appendicitis. He was a Fellow of the Institute of Chemistry and the Chemical Society, an ex-Vice-president of the Society of Public Analysts, and at the time of his death filled the office of Public Analyst for Hammersmith and Colchester.

EDWARD WILLIAM ORTON, L.R.C.P.Ed.,  
M.R.C.S.Eng.

AT Bedworth, on the 7th inst., the death occurred of Mr. Edward W. Orton, one of the best-known medical practitioners in North-east Warwickshire. He was the last of the old school of sporting doctors of that part of Warwickshire, and to within a few years ago was a regular follower of the Atherstone foxhounds. Deceased was 63 years old, and had held many public appointments, including that of Medical Officer and Public Vaccinator of the Bedworth District. He was educated medically at Queen's College, Birmingham, and in 1870 took the London M.R.C.S., and the Edinburgh L.R.C.P. and L.M.

JAMES WALLACE, M.A., M.D.Glasg., L.R.C.S.Ed.

DR. JAMES WALLACE, Medical Officer of Health for Greenock, was found dead in bed on the morning of the 10th inst. He retired to rest on Sunday night apparently in his usual health. He was in his eightieth year, and was one of the oldest physicians in Scotland. Deceased had held numerous appointments, including that of Physician to Greenock Infirmary and Examiner in Surgery and Clinical Surgery in Glasgow University. He took the Glasgow degree of M.D. in 1850, L.R.C.S. Edin. and F.F.P.S.Glasg. in 1851.

#### Literature.

REPORT OF THE PRISONS BOARD, IRELAND. (a)

OF 19 preliminary pages of this blue-wrapped volume, the "Report" proper occupies but 13. An Appendix, of matters manifold, constitutes the bulk of the contents, as it runs to 159 pages. Such a document as the present possess, of course, an interest for civilised humanity in general, and for the theorising philanthropist in particular; but most particularly of all for the most practical of all living philanthropists, the truly representative medical man who is devoted to the practice of his profession. The present report presents but comparatively trifling variations in the statistics of committals from those of the last preceding. "The number of criminal prisoners committed to the local prisons during the year 1903 was 32,294, and the daily average number in custody 2,296. These figures show a decrease of 101 and 30 respectively, compared with the corresponding figures for the previous year. In addition to the numbers above, 74 prisoners were committed to local prisons during 1903, under civil process, being an increase of 12 compared with the previous year. The number committed to bridewells during the year was 455, being 227 less than during the previous year." The compilers of the present report "concur in the conviction expressed by the Prison

(a) "Twenty-sixth Report of the General Prisons Board, Ireland" 1903-04; With an Appendix. Dublin: Alex. Thom and Co., Limited.—1904.

Commissioners for Scotland in their last Annual Report as follows: 'It is our conviction that short sentences of imprisonment are not only useless for reformation, but actually harmful to the prisoner.' As a large proportion of such punishments are inflicted on parties convicted of the time-honoured practice of being "drunk and disorderly," it is very easy to comprehend the accuracy of this view. And as the bulk of such cases are always supplied by the dregs of the population of the cities and larger towns, they do not very well represent any portion of the general morality of a nation. Cities are always cities, and always will be so long as human nature and its unsatisfactory craving remain the same. Turning to the table which sets forth the number of sentences to penal servitude passed in Ireland at various periods, the view is much more encouraging. The first year included in this table is 1855, the last is 1903. The number convicted in the former year was 518, in the latter 79. The decline was not uniform; after having dropped to 68 in the year 1897, it rose to 91 in 1898; in 1899 the number was 89; in 1900 it fell to 59; another wave carried it up to 75 in 1901; after which it dropped in 1902 to 57, the lowest record of all. As Ireland has for the past quarter of a century been gradually passing through the throes of a revolution, the records of brutal and otherwise atrocious crime perpetrated in the country during that period are decidedly encouraging. Even in the worst years of the "agitation," when agrarian outrages were at their highest record level, the proportion of murders to the total population of Ireland was one of the lowest of any community in the world. The reins of Government have now been transferred to the people; we sincerely hope that one of the most conspicuous results of the change will be a progressive diminution of crime. The philosophy of history teaches that in all countries and in all ages, the inevitable result of the ruthless administration of draconic laws has been an increase of the worst forms of crime. When the philosophic physician and enthusiastic naturalist, Andreas Sparrmann, M.D., visited South Africa (1772-1776), his observations on the relationships of the Dutch Colonists and their Hottentot slaves, and Hottentot and Bosjesman neighbours inclined him to entertain the surmise that the earliest practice of cannibalism among the savage races of any country was a result of brutal oppression. Breaking on the wheel and subsequent impalement was a frequent termination of the life of a recalcitrant slave. The impaled and mangled convict often lived for several days. The Cape passed into the hands of the English, and such forms of capital punishment were abolished. When John Barrow visited the colony a quarter of a century later, he found that the executions had become so few after the amelioration of the law that one of the two hangmen had, in a state of want and despair, officiated on himself!

### Medical News.

#### The Royal City of Dublin Hospital.

At a meeting of the Directors of this hospital, held on Thursday last, the vacancy in the visiting staff due to the death of Dr. J. L. Lane, Gynæcologist to the hospital, was announced, and it was decided to hold the election about the middle of November. We understand that already some half-a-dozen candidates are in the field.

#### The Medico-Legal Society.

The third annual general meeting was held on October 11th at the rooms of the Society, 22, Albermarle Street, W., when the following officers were appointed for the ensuing session:—President, Sir Wm. Collins, F.R.C.S. Vice-Presidents, Dr. Matthew Hay, Dr. Bostock Hill, Mr. C. H. Hopwood, K.C., Sir Thomas Stevenson, M.D., and Mr. Justice Walton. Treasurer, Mr. John Troutbeck, M.A. Council, Dr. Danford Thomas, Dr. J. G. Carson, Dr. Harvey Littlejohn, Dr. Wm. McCallin, Earl Russell, Mr. Walter Schröder, Dr. Clave Shaw, Dr. F. J. Smith, and Dr. Wynn Westcott. Secretaries, Mr. R. Henslowe Wellington and Dr. Stanley B. Atkinson.

#### Royal Academy of Medicine.

THE annual meeting of the Royal Academy of Medicine in Ireland was held in the Royal College of Physicians on Friday last, when the following officers for the ensuing year were elected:—President, Sir Thornley Stoker; General Secretary, James Craig; Secretary for Foreign Correspondence, Sir J. W. Moore.

*Medical Section.*—President, the President, R.C.P.; J. B. Coleman, W. R. Dawson, H. C. Drury, T. P. Kirkpatrick, G. Peacocke, F. C. Purser, R. Travers Smith, W. Langford Symes, W. J. Thompson, W. A. Winter.

*Surgical Section.*—President, the President, R.C.S.; Alexander Blayney, T. E. Gordon, John Lentaigne, R. B. M'Causland, R. C. B. Maunsell, Sir Lambert Ormsby, John B. Story, E. H. Taylor, W. Taylor.

*Obstetrical Section.*—President, A. J. Smith; Paul Carton, R. H. Fleming, R. A. Flynn, J. H. Glenn, A. J. Horne, H. Jellet, F. W. Kidd, W. C. Neville, R. D. Purefoy, T. H. Wilson.

*Pathological Section.*—President, H. C. Earl; A. H. Benson, H. C. Mooney, T. G. Moorhead, A. C. O'Sullivan, A. R. Parsons, F. C. Purser, J. A. Scott, John B. Story, A. H. White.

*Section of Anatomy and Physiology.*—President, Edward Taylor, A. Birmingham, D. J. Coffey, A. F. Dixon, A. Fraser, J. Alfred Scott.

*Section of State Medicine.*—President, Sir J. Moore; W. R. Dawson, F. C. Martley, J. M. Redmond, W. A. Winter.

Professor Fuchs, of Vienna was elected an Honorary Fellow. A resolution of thanks to the retiring General Secretary was unanimously adopted.

#### Glasgow Eastern Medical Society.

THE opening meeting of the session was held on October 5th, when the President, Dr. James Dunlop, delivered an address on the Sanatorial Treatment of Consumption. The following were elected office bearers for the session 1904-05:—President, Dr. James Dunlop. Vice-President, Dr. Miller Semple. Secretary, Dr. P. S. Buchanan. Treasurer, Dr. J. Wilson Mathie. Reporting Secretary, Dr. Hugh H. Borland. Sealkeeper, Dr. Thomas Russell. Council, Dr. Joseph Green, Dr. John A. C. Macewen, Dr. A. Laurie Watson, Dr. John Anderson, Dr. W. Adam Burns, and Dr. John W. Finlay. Auditors, Dr. Robert Wilson and Dr. T. C. Barras.

#### Meath Hospital.

THE Session at the Meath Hospital was opened on Tuesday by Mr. Conway Dwyer, who delivered an interesting address on "The Evolution of Modern Surgery," which we hope to publish in our next number. Sir Francis Cruise, M.D., occupied the chair. On the motion of Sir Thomas Myles, seconded by Sir Lambert Ormsby, a vote of thanks was passed to Mr. Dwyer. A similar vote to the Chairman was passed, on the motion of Sir John Moore.

#### Glasgow Southern Medical Society.

THE opening meeting of the tenth session of this Society was held on October 6th, and the following office-bearers were elected for the ensuing year:—Honorary President, Mr. H. E. Clark. President, Dr. J. Hamilton. Vice-Presidents, Professor R. Stockman and Dr. T. K. Munro. Treasurer, Dr. T. Forrest. Secretary, Dr. J. Weir. Editorial Secretary, Dr. R. W. Forrest. Sealkeeper, Dr. A. Wauchope. Extra members of Council, Dr. John Stewart, Dr. D. Macgilvray, and Dr. R. J. Carroll. Court Medical, Mr. T. Richmond Dr. J. C. A. Smith, Dr. G. H. Edington, Dr. A. Roxburgh, and Dr. John Brown. Governor of Victoria Infirmary, Dr. C. E. Robertson.

#### St. Vincent's Hospital, Dublin.

DR. M. McHUGH delivered the introductory address at the opening of the winter session at St. Vincent's Hospital, Dublin, on Wednesday, in which he dealt with the position and demands of the dispensary doctors who, he said, numbered, roughly, 50 per cent. of the profession in Ireland. His address is published in another column. Mr. O'Neill, Chairman of the Dublin District Council, in moving a vote of thanks to Dr. McHugh, said that whenever the local bodies made an

effort to do even a minor justice to the unfortunate dispensary doctors, the Local Government Board erected every barrier and obstacle that they could possibly conceive in order to prevent these remedial measures being carried out. His advice to the profession was to organise and agitate. Dr. Cox seconded. The Chairman (Mr. Waldron, M.P.) thought the demands reasonable. Surgeon-General Evatt, C.B., was moved to the second chair, and a vote of thanks was passed to Mr. Waldron on the motion of Mr. McArdle, seconded by Mr. Tobin, which was passed unanimously.

#### Dublin Hospital Appointments.

DR. DAVID GRAY, who filled the position of House Surgeon for some time past at Jervis Street Hospital, has been appointed House Surgeon at the Westmoreland Lock Hospital. Dr. L. J. Farrell succeeds Dr. Gray as principal house surgeon, and Dr. W. B. Loughman is appointed to fill the vacancy on the Jervis Street Hospital staff.

#### South-West London Medical Society.

THE annual dinner of this Society was held at the Café Monaco, Piccadilly Circus, London, W., on October 7th, when about 50 members and guests were present. The chair was taken by Mr. E. F. White, the President. The toast of "The Society" was proposed by Dr. W. H. Allchin, and responded to by the President. Surgeon-Major Mark Robinson proposed "Our Kindred Societies and Visitors," to which Sir R. Douglas Powell and Mr. F. F. Burghard replied.

#### Society for the Relief of Widows and Orphans of Medical Men.

At the quarterly Court of Directors, held on Wednesday last, October 12th, at 11, Chandos Street, London, W., Dr. Blandford, treasurer, in the Chair, three new members were elected and the death of a member reported. There were no fresh applications for grants. The death of a widow was announced, who had received £957 since January, 1879. Applications for renewal of grants were received from 52 widows, 13 orphans, and 3 orphans on the Copeland Fund, and it was resolved that £1,293 be distributed at the next court subject to the report of the visitors. On the motion of the acting treasurer it was decided to give at Christmas £10 to each of the 52 widows, £3 to each of the 13 orphans, and £5 to each of the 3 orphans on the Copeland Fund—in all, £574. The expenses of the quarter were £60 14s. 6d.

#### International Congress of Surgeons.

PRESIDENT LOUBET opened the seventeenth International Congress of Surgeons in Paris on Monday last, and yesterday Dr. Doyen, the free lance of the profession in that city, was announced to read a highly contentious paper on "The New Treatments of Cancer," of which we shall probably hear more anon.

#### PASS LISTS.

##### University of Durham—Faculty of Medicine.

The following degrees in Medicine and Surgery were conferred on October 1st:—

*Doctor in Medicine.*—John S. Hall, M.B., B.S.Dur., John R. Halliday, M.B.Dur., Frank Jeffree, M.B.Dur., Alfred Parkin, M.B., B.S.Dur., F.R.C.S., Godfrey de Bec Turtle, M.B., B.S.Dur., and William H. Wigham, M.B.Dur.

*Doctor in Medicine for Practitioners.*—Ernest D. Bower, M.R.C.S., F.R.C.S.E., Beaumont H. Comerford, M.R.C.S., L.R.C.P., Philip H. Dunn, M.R.C.S., L.R.C.P., John K. Frost, M.R.C.S., L.S.A., D.P.H., William V. Furlong, L.R.C.S.I., L.R.C.P.E., Frank K. Holman, M.R.C.S., L.R.C.P., Richard M. Hugo, L.R.C.P.I., L.M., F.R.C.S.I., Thomas S. Jones, M.R.C.S., L.R.C.P., F. St. John Kemm, L.R.C.P. and S., L.S.A., Arthur C. A. Lovegrove, L.S.A., Thomas H. Mitchell, L.R.C.P. and S.E., Herbert E. Rowell, M.R.C.S., L.R.C.P., George J. Smith, L.R.C.P. and S., L.M., James B. Wall, L.R.C.P. and S., George R. Williams, M.R.C.S., L.R.C.P.

*Master in Surgery (M.S.).*—Lachlan G. Fraser, M.D., B.S.Dur., and Alfred H. Proctor, M.B., B.S.Dur.

*Bachelor in Medicine (M.B.).*—John A. Bell, Henry M. Braithwaite, Arthur Budd, Llewelyn A. H. Bulkeley,

Lewis A. Clutterbuck, L.R.C.P. and S.Ed., L.R.C.P.I., William E. Falconar, Harold E. Featherstone, Margaret D. French, Norman H. Hume, Thomas C. Hunter, Sophia B. Jackson, William W. Jones, George E. Lloyd, Colin F. F. McDowall, Stanley Robson, William T. Sewell, Arthur L. Sheppard, William E. Stevenson, William L. Tindle, Janet A. Vaughan, Samuel G. Webb.

*Bachelor in Surgery (B.S.).*—John A. Bell, Henry M. Braithwaite, Arthur Budd, Llewelyn A. H. Bulkeley, Lewis A. Clutterbuck, L.R.C.P. and S.Ed., L.R.C.P.I., Harold E. Featherstone, Margaret D. French, Norman H. Hume, Thomas C. Hunter, Sophia B. Jackson, William W. Jones, George E. Lloyd, Colin F. F. McDowall, Stanley Robson, William T. Sewell, Arthur L. Sheppard, William E. Stevenson, Janet A. Vaughan, Samuel G. Webb.

*Diploma in Public Health (D.P.H.).*—Charles R. Stewart, M.B., B.S.Dur., and John Stokes, M.D., B.S., L.S.Sc.Dur., M.R.C.S.

#### Royal Colleges of Physicians and Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE following gentlemen, having passed the requisite examinations of the Conjoint Board, were admitted Diplomates in Public Health:—James Allison, M.B., C.M., Kershaw Dinshah Khambatta, L.M. and S., L.R.C.P. and S.E., Alfred Robert Maclurkin, M.B., Ch.B., Daniel Mackinnon, M.B., Ch.B., Richard Staward, F.R.C.S.E., Alexander Mouat, M.B., Ch.B., Lambert Kenneth Rodriguez, L.R.C.P. and S.E., Herbert Francis Lechmere Taylor, M.B., C.M., Herbert De Carle Woodcock, M.R.C.S. Eng., L.R.C.P. Lond., and David Dryburgh Gold, M.B., C.M.

At the same Sederunt, Messrs. James Alexander Raeburn, M.B., Ch.B., and Mowbray Taylor, M.B., C.M., passed the first examination in Public Health; and Mr. Robert Dods Brown, M.B., Ch.B., passed the second examination in Public Health.

#### Society of Apothecaries of London.

At the primary examination the following candidates passed in the subjects indicated:—

*Part II.*—Anatomy: L. W. Bradshaw, Leeds; A. C. Dickson, Guy's Hospital; J. W. Harrison, St. Mary's Hospital; L. R. Nézet, Edinburgh; H. N. Ritchie, Sheffield; and N. C. Wallis, London Hospital. Physiology: R. Beesley, Manchester; L. W. Bradshaw and T. P. Braim, Leeds; J. W. Harrison, St. Mary's Hospital; W. P. Pinder, Leeds; H. N. Ritchie, Sheffield; and N. C. Wallis, London Hospital.

#### The Royal University of Ireland.

*The Third Examination in Medicine—Autumn, 1904.*—The examiners have recommended that the following candidates be adjudged to have passed the above-mentioned examination:—

*Upper Pass.*—James J. A. Gannon, Charles R. Harvey\*, Robert J. Ledlie, Victor J. McAllister, Patrick T. McArdle\*, Charles B. Pearson\*, Percy B. Ridge, Charles H. G. Ross, James Shaw\*, Thomas Tobin\*, James Warnock\*, M.A. Those marked with an \* may present themselves for the further examination for honours.

*Pass.*—Harry L. Bristow, Francis X. J. Callaghan, John A. Clarke, John Dempsey, John Dunlop, Patrick J. Dwyer, Isaac Flack, William J. Hill, James Horgan, Charles G. Knight, Samuel W. Kyle, Morgan Leane, Thomas J. McAllen, Samuel McCormac, Robert A. M. L. McCrea, Jerome B. Murphy, Joseph Nunan, Joseph A. O'Halloran, Maurice A. Power, William B. Purdon, Patrick Reid, Maria Rowan, Richard V. Slattery, B.A., Peter Walsh, Ernest J. Watson, and Jemina B. White.

THE Army Medical Service Advisory Board, the members of which are Sir C. B. Ball, M.D., Sir E. Cooper Perry, M.D., Sir Frederick Treves, Bart., K.C.V.O., F.R.C.S., and Dr. J. Galloway, has been appointed for a further period of three years.

## 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.

**DR. HELFIELD.**—Your paper on Mediterranean Fever is unavoidably held over for want of space.

### THE BOSGIAN BOWL.

For salads *le d'avier cri* is flowers, something gay and pretty to adorn the bowl.—*The Lady.*

Fair to the sight that bowl may seem,  
Denked out with all the spoils of Flora,  
But what if its contents should seem  
With poppy blooms and mandragora?  
Talk spikes of foxglove charm the eye,  
But, though dished up *cum grano salis*,  
Few gourmets would consent to try  
A bowl of seasoned digitals;  
Or bear more love than even Shelly bore

T'ward hemlock, aconite, and hellebore!—*Truth.*

**EDINBURGH STUDENT.**—From inquiries made we understand there is not to be a new edition of the book at present, the authors considering it quite up-to-date.

**MR. WALTON CLARKE.**—It is a question outside the sphere of medical journalism, and we cannot undertake to reply.  
**DR. BOYD and DR. DUFF.**—See notice to Dr. Hefield.  
**MR. DAVID OWEN.**—Your communication came to hand as we were "at press," the subject will be dealt with in our next.

### IMPOSITIONS ON MEDICAL MEN.

This paragraph is written to prove that even a doctor will turn. A man called upon one not long ago to be examined. The doctor examined him and wrote out a prescription. When told what the fee was the patient asked to be allowed to owe the amount as he had been out of work for some weeks, and was short of funds. As he seemed a decent sort of fellow the doctor granted his request. The man profusely thanked him, and then asked what it would cost to have the prescription made up. On learning that five shillings would about cover it, he asked the doctor if he would supplement his kindness by lending him the money. That was just a little too much for the man of medicine. He seized the prescription from the patient's hand, and said, "This prescription, I'm afraid, my man, will not quite do in your case. I've been treating you for nerves."  
*Daily Chronicle.*

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 19th.

**ROYAL MICROSCOPICAL SOCIETY** (20 Hanover Square, W.).—8 p.m. Dr. D. H. Scott (President): Demonstration on the Reconstruction of a Fossil Plant.

**MEDICAL GRADUATES' COLLEGE and POLYCLINIC** (22 Chancery Street, W.C.). 4 p.m. Mr. C. Ryall: Clinique. (Surgical.) 5.15 p.m. Sir A. D. Fripp: Recent Variations in the Technique of Certain Common Operations.

THURSDAY, OCTOBER 20th.

**MEDICAL GRADUATES' COLLEGE and POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. P. Stewart: Facial Paralysis.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION and DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. J. E. Squire: The After-Effects of Pleurisy (Illustrated by cases). (Post-Graduate Course.)

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture: Mr. W. Edmunds: Diseases of the Prostate.

FRIDAY, OCTOBER 21st.

**MEDICAL GRADUATES' COLLEGE and POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Dr. H. Tilley: Clinique. (Throat.)

**SOCIETY FOR THE STUDY OF DISEASES IN CHILDREN** (11 Chandos Street, W.).—5.30 p.m. Cases will be shown by Dr. C. O. Hawthorne, Dr. B. Hutchinson, Mr. S. Stephenson, Dr. L. Guthrie, Mr. A. Edmunds, Dr. Cautley, Mr. G. Pernet, and others. Papers: Mr. A. C. Lucas: On an Ill-developed Upper Lateral Incisor Tooth as a Fore-runner of Harelip or Cleft Palate.—Dr. S. Gilford: On Two Cases of Congenital Diaphragmatic Hernia.

MONDAY, OCTOBER 24th.

**ODONTOLOGICAL SOCIETY OF GREAT BRITAIN** (20 Hanover Square, W.).—8 p.m. Mr. J. F. Colyer, L.R.C.P.Lond., M.B.C.S., L.D.S., Eng. "Some recent additions to the Museum of the Society." (Illustrated by Lanterna Slidea.)

TUESDAY, OCTOBER 25th.

**THERAPEUTICAL SOCIETY** (Apothecaries' Hall, E.C.).—4 p.m. Annual General Meeting. After which paper will be read by Dr. Harris: On some Therapeutical Applications of the Continuous Current.

## Vacancies.

**Horton Infirmary, Banbury.**—House Surgeon. Salary £200 per annum, with board and residence in the Infirmary. Applications to the Honorary Secretary, 21 Marlborough Road, Banbury.

**Darlington Hospital and Dispensary.**—House Surgeon. Salary £120 per annum, with board and lodging in the Institution. Applications to the Secretaries, 48 Stanhope Road, Darlington.

**Somerset and Bath Asylum, Cotford, Taunton.**—Assistant Medical Officer. Salary £160 per annum, with furnished apartments, board, fuel, lighting, and washing. Applications to the Medical Superintendent.

**Down District Lunatic Asylum.**—Junior Male Assistant Medical Officer. Salary £100 per annum, with furnished apartments, &c. Applications to the Resident Medical Superintendent.

**East London Hospital for Children and Dispensary for Women, Shadwell, E.**—Resident Medical Officer. Salary £100 per annum, with board, residence, and laundry. Applications to Thomas Hayes, Secretary.

**Devon County Asylum.**—Second Assistant Medical Officer. Salary £150 per annum, with board, lodging and washing. Applications to the Medical Superintendent, the Asylum, Exminster.

**Wakefield West Riding Asylum.**—Assistant Medical Officer. Salary £140 per annum, with apartments, board, washing, and attendance. Applications to the Medical Director at the Asylum.

**Bury Infirmary.**—Junior House Surgeon. Salary £200 per annum, with board, residence and attendance. Applications to the Hon. Secretary, Dispensary, Knowsley Street, Bury, Lancashire.

**The Municipal Corporation of Port Elizabeth.**—Medical Officer of Health. Salary £250 per annum. Applications to Davies and Soper, Agents of the Municipal Corporation of Port Elizabeth, 54 St. Mary-axe, London, E.C.

**Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.**—Senior House Surgeon. Salary £100 per annum, with board and residence in the Hospital. Applications to Robert J. Bland, Secretary.

## Appointments.

**BLACKFORD, JAMES VINCENT, M.D., B.S.Durh., L.R.C.P.Lond., M.R.C.S.,** Medical Superintendent at the City and County Asylum, Fishponds, Bristol.

**GUNN, ALBERT, A., M.B., Ch.B.Edin.,** Honorary Assistant Physician to the Blackburn and East Lancashire Infirmary.

**HEATCOTE, HENRY, CHARLES, M.B., B.Ch.Vict.,** Medical Officer for the Fawton St. Loe District by the Keynsham Board of Guardians.

**LEITCH, MORTON EDWARD, M.D. BRUX., L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasg.,** Medical Officer for the Lerryn District of the Liskeard (Cornwall) Board of Guardians.

**MARTIN, JOHN M. H., M.D.Vict., F.R.C.S.Eng., J.P.,** Honorary Consulting Surgeon to the Blackburn and East Lancashire Infirmary.

**MORGAN, THOMAS WHITWORTH SEWELL, M.B.C.S.Eng., L.S.A.,** Medical Officer for the Preston District by the Keynsham Board of Guardians.

**SAWYER, JAMES E. H., M.A., M.D. Oxon., M.R.C.P.Lond.,** Pathologist at the General Hospital, Birmingham.

**STEVENS, ROLAND A., L.R.C.P., M.R.C.S.Eng.,** Medical Superintendent at the London Open-air Sanatorium, Pinewood, Wokingham, Berks.

**WADMORE, J. CHRISTOPHER, L.R.C.P.Lond., M.B.C.S.Eng.,** Assistant Resident Medical Officer at the London Sanatorium, Pinewood, Wokingham, Berks.

## Births.

**ABRAM.**—On October 15th, at Reading, the wife of G. Stewart Abram, B.A., M.B., of a son.

**HARRIS.**—On October 16th, at 12 Buckingham Place, Brighton, the wife of Henry Arthur Clifton Harris, M.R.C.S., L.R.C.P., of a daughter.

## Marriages.

**ALINGTON—TOOTH.**—On October 15th, at St. Andrew's, Wells Street, Argentine Hugh Alington, Lieut. R.N., son of Admiral Alington of Swinhope, Lincolnshire, to Janet Marchant, daughter of Howard H. Tooth, M.D., C.M.G., of 34 Harley Street, London, W.

## Deaths.

**BRICKWELL.**—On October 16th, at Somerset, Huntingdonshire, Betsy, widow of the late Henry Brickwell, M.R.C.S., L.S.A., of Somersham.

**THORNTON.**—On October 16th, at 8, West Park Gardens, Kew, Jess Thornton, the widow of the late Philip Thornton, M.R.C.S.

## ROYAL CITY OF DUBLIN HOSPITAL.

A vacancy exists for the position of Gynecologist. Applications to be sent on or before 29th Inst., to the Hon. Sec., Medical Board, Mr. G. Jameson Johnston.



# The Medical Press and Circular.

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## Original Communications.

### THE LACK OF PRACTICAL METHODS IN MODERN SURGICAL EDUCATION. (a)

By EDMUND OWEN, F.R.C.S.,

Consulting Surgeon to St. Mary's Hospital, London.

FROM the intimate acquaintance which I have with William Hey, the illustrious founder of this Leeds General Infirmary, I feel convinced that if he could come back for a day or two and follow you about, he would say that the present system of medical education was unsatisfactory; and I feel equally sure that if he had been brought under this system, English surgery would have been robbed of one of its brightest luminaries.

Hey was enabled without any interference to devote the whole of his first winter to the practical study of anatomy. He seldom spent less than twelve hours a day at anatomy, which he considered as the foundation of surgical science. You would consider yourselves fortunate, I dare say, if you could manage to secure three hours on end in the dissecting-room—and even then you would probably be tempted to leave off in the middle of your interesting work in order to attend some demonstration, for you have been brought up in the belief that the knowledge of anatomy is best acquired by being *taught* it. This was not Hey's opinion. He was a practical anatomist at the beginning and always, and when he became a practical surgeon he still kept a close hold upon his anatomy. He was a most strenuous worker, and knew exactly how to set about his studies, and how to obtain the greatest advantage from them. "Being aware," says his friend, "of the disadvantage of engaging himself with a multiplicity of objects at the same period, it was his method to direct his *principal* attention to one subject at a time without, however, absolutely neglecting others when his leisure would permit." That is to say, when he was working at anatomy he might, if he could spare the time from it, attend a lecture upon some outside subject, but not otherwise.

Had he been living at the present time the Dean of his medical school would be told that he was not working at practical chemistry, or histology, or that he was not attending some course of lectures which absolutely failed to interest him, and from which he was unable to learn anything. If Hey had been a student at the present time he would have been strangled by the red tape with which he would find his course hampered.

#### FAILURE AT SURGICAL EXAMINATIONS.

A few months ago, the President of the Royal College of Surgeons, Mr. John Tweedy, called attention to the fact that students were not acquitting themselves as satisfactorily at their final examinations in surgery as was formerly the case; he regarded the matter as worthy of serious consideration, and he asked if any explanation of the fact were forthcoming, and if any-

thing could be done towards remedying it. In an attempt to answer this question, I would say, in the first place, that no equivalent has ever been devised for the old apprenticeship system, and, in consequence, every year the student's training is becoming less practical. We hoped that the "fifth year of study" was going to make good some of the deficiencies left in our scheme of education, but we have been grievously disappointed. I am not going to ask for a restoration of the apprenticeship system; to go back to it would be as undesirable as impossible; still the system was not without great merits, for it made a man quick, handy, and resourceful. It enabled him confidently to recognise and treat a fracture or dislocation, and to apply a splint and a bandage in a manner which would, I expect, put most of you to shame. The senior student of former days could bleed a man, and he could pass a catheter, and he might be trusted to do every operation in minor surgery long before he had begun to think of his final examination. But at the present day students are not *practical*. They fall lamentably short in their *clinical* work, up to which, I need hardly remind you, their entire educational course is supposed to lead. Their clinical knowledge is to be their chief future asset in their daily professional life, for the training of the medical student is not to make him a biologist, a chemist, or even an anatomist, but to teach him to recognise disease with precision, and to deal with it with satisfaction to the sick people under his care. I have no hesitation in affirming that, in these respects, the training of the medical student of to-day is not nearly as thorough and efficient as it was in the time of William Hey.

#### SURGICAL VENEERING.

The students of to-day are depending far too much upon "coaching." They seem to think that time spent in steady work at the bedside and with the patient might be more profitably employed in some special form of tuition. I regret to say that year by year they are coming less into personal contact with patients. They listen to demonstrations on cases; they discuss the problems of disease with their tutors, and they occasionally attend a clinical lecture, but actual work with the patients themselves is every year diminishing. The result is that they fail lamentably in the clinical part of their tests. They do not know how to set about investigating a case with a view to diagnosis. They do not understand, for instance, how to handle a case of hip-disease, and still less to estimate the amount of deformity at the joint. They do not know how to investigate a case of infantile paralysis, and many of them seem to have had no personal experience with the translucency test for hydrocele. All these methods of procedure are in daily use in the out-patient department and in the wards, where the senior students ought to be spending most of their time. But they are not there; they trust to acquiring a minimum clinical veneer at the "college-class." They tell me that they have not time for work in the wards!

In the course of a *visû voce* examination in surgery, with the object of making it a personal, living matter, and of getting a practical answer from the candidate, it was often my custom to introduce a subject thus:

(a) Abstract of an Address delivered to the students of the Leeds Medical School, October 15th, 1904.

"You have seen a case of so and so?" Then, on the candidate saying "Yes," I would ask him to describe the case and the treatment of it, just as if we were looking at it together in the hospital-ward. But of late I have had to give it up, because of the frequency with which the reply was that he had "never seen such a case." It is disheartening to an examiner to be told, for instance, that the candidate has never seen a case of infective osteo-myelitis. I can quite understand that a student has never seen a patient with erysipelas, or delirium tremens, for such cases are now promptly taken from a general ward and placed in beds which, are, unfortunately, far removed from the student's sphere of exercise. And I can realise the fact that he may never have seen a case of pyæmia, or of traumatic spreading gangrene, for the simple reason that surgical cleanliness has made such diseases—common enough in my student days—of comparative rarity. But the cases to which I refer are such as one constantly finds in a general surgical ward. "What! never seen a man with extravasation of urine?" "No." "What! never seen a case of renal calculus?" "No."

Ask any of your surgical friends who were students in the seventies and eighties if they found time for making a practical acquaintance with surgical cases, and you will probably be told that they spent a couple of hours in the wards in the morning with the house surgeon, and that they were there again, and in the operating theatre, for another two hours with the surgeon of the day, not only when they were dressers but subsequently, and that on many days they were hanging about the surgical department of the hospital until late in the evening. I have no doubt that many of you would adopt that plan if you were a little more masters of your time. But you reply that you have not time enough for all that you have to do.

#### THE "FIFTH YEAR."

"Not sufficient time?" says the student of former days. "Why, the General Medical Council have given you a *fifth* year of study; we had but *four* years!" Yes, this is true, but it has turned out a bitter disappointment. It has considerably increased the expense of medical education, but it has missed its mark entirely. It ought to have been made "the practical year," but the authorities have allowed it to be frittered away, and for all the practical, professional good that the medical student obtains from it, he might almost as well have spent it at school.

One of the chief reasons for students not having "sufficient time" for practical surgery is that many of them have been kept back by their chemical work. The examinations in chemistry for medical students suggest that the examiners think that chemistry is going to be the chief occupation of the individual when he is in practice. It is much the same with physics, and the sooner that its standing is placed at a common-sense level the better. The Medical Council have already accomplished so much in the cause of education that it is not improbable that they will ere long see fit to make some change in the direction of greater freedom, and one which will help towards securing for the student an increasing store of *practical* knowledge.

On all sides I hear complaints of this want of practical knowledge on the part of those who have recently obtained their qualification. Thus, a general practitioner finds himself in need of an assistant, and he applies to some friend upon the staff of his old hospital to send him a likely man. In answer to his application one of the most promising students is sent, one, may be, who took the prizes in biology and chemistry. But in a little while the practitioner writes to say that the so-called "assistant" is no help whatever; that though he is an adept in the art of prescribing drugs of doubtful value but of undoubted expense, he knows, *practically*, nothing of his profession; that he cannot be trusted in anything; that all his work must be closely supervised; that his diagnoses are as extra-

vagant as they are improbable; and that though he can talk eloquently about Bassini's operation he cannot diagnose a simple hydrocele; that he mistakes scarlet fever for measles, and swollen cervical glands for mumps; that he treats the diarrhoea of intestinal cancer with chalk and opium (without ever thinking of making a digital examination of the rectum); and that he applies a fomentation to the painful knee of a boy with early hip-disease.

Let me urge upon you to get through your preliminary science examinations as quickly as possible, so that you may the longer occupy yourselves in clinical work. Do your best to attend regularly in the out-patient department, and never for one moment fancy that you are wasting time because so few of those applying for relief are the subjects of diseases of an unusual type. When you get into actual practice the experience thus acquired will prove far more serviceable to you than that which has been obtained in listening to clinical lectures upon certain rare cases, or, may I say it, than the instruction which you obtained in "special classes"!

As things are, the dreaded examination becomes due before the candidate is ready to meet it. He feels that he does not know his work, but he is under the impression that the most likely way of leading his examiners to think that he does is by obtaining a surgical polish at the hands of an experienced "coach." This gentleman is probably an able and energetic young surgeon, who has already acquired considerable reputation both as a student and a teacher, in addition to which he is possibly regarded as an astrologer of some merit. That is to say, by making a prolonged and careful study of the past examinations, he has acquired the art of guessing what questions are going to be set at the forthcoming one. He has, in other words, elaborated a "system," which sometimes works out with extraordinarily good results. But the literary style imparted by some of these coaches—if I see it correctly reflected in the paper-work of their pupils—is not a high one. For a very favourite method of writing an answer to a question consists in drawing one or two straight lines vertically down the folio, and inserting in the respective columns the symptoms of one disease as compared with those of another, or the headings of the schemes of treatment appropriate for them. This method is constantly recurring in answer to questions involving differential diagnosis, the columns being as destitute of verbs as are the pages of an auctioneer's catalogue. I do not know how this method originated, but I rather think that certain coaches, in the endeavour to impart knowledge, tabulated, exact and concentrated, plan out their teaching in this manner upon a blackboard in front of the class. It is science in the tabloid form. Some of the papers written by senior students would, so far as literary merit is concerned, scarcely reflect credit upon a pupil from a Board School, and if I might presume to address a few words to "coaches," I would say that unless they themselves write decent English they cannot impart the art to their students. And if they deign to inquire to what source I would refer them for style, I would say, the Gospels, the "Pilgrim's Progress," and the "Sentimental Journey."

The current style of English medical literature is, for the most part, tedious to the last degree, and now that dear old Mitchell Banks' pen is for ever dry, there are few to brighten the pages of our journals and to charm the reader.

You should make an attempt at style even in your ward-notes; and so, later on, when you are preparing a full account of your own extraordinary success in the treatment of a series of medical cases with some new and fashionable drug (and you must be quick, for new and fashionable drugs are soon found to have lost their efficacy), or some wonderful results obtained in operative surgery, take pains with the preparation of your paper, and if you cannot make it attractive, at least make it readable—and not too long.

By the present scheme of education far too much

*teaching* enters into the daily life of the medical student. He is lectured to, catechised, and crammed until a sort of intellectual dyspepsia is induced in him, and he is unable to *learn*. Moreover, from want of proper mental exercise, he has almost lost the desire to learn. All his intellectual food is served to him hot, finely divided, and peptonised. His wisdom-teeth are of no further use. He goes up for his practical examinations at regular intervals, and he comes back rejected. "Poor fellow," say his friends, "how unlucky he is! He certainly deserves to pass, for he is such a steady worker."

I was once asking a candidate to describe the operation of herniotomy, and his description ran thus:—"Then you enlarge your wound and expose your sac"; and, later, "Then you separate your omentum from the wall of your sac." I maintain that when a candidate is asked to describe his method of treatment he has no right to use this second personal pronoun. When I have put my question I want the answer to suggest, as it were, the candidate performing the very operation step by step. Again, I was asking a candidate to describe the early stages of a certain disease, and he said, "And then your inguinal glands become enlarged, and you break out in secondaries"! When I asked him to be somewhat more impersonal in his reply, it did not seem to dawn on him that he had been thoughtless, for he quickly went back to the use of the second personal pronoun, and did not leave me until I was a hopeless physical wreck!

"Oh," says the candidate, in answer to the question as to what treatment he would advise in a case of diphtheritic disease of the knee-joint, "you might try"—notice the pronoun and the auxiliary verb—"Scott's dressing." When asked what Scott's dressing is, he has not the least idea. Asked how he would treat a case of mammary carcinoma with wide-spread implication of the cervical glands, he replies, "'You' might remove the breast"!

Ought a man who talks like this to be trusted in actual practice?

I do not condemn altogether the so-called college-classes and the special instruction classes. Possibly the system of education and the exigencies of examinations have rendered them almost a necessity; and it may be that, to a limited extent, they perform a useful function in our schools. But what I must insist on is that students ought not to be encouraged to place as much reliance on them as they do at present. For though they may help a man to scrape through an examination, they ought not for a moment to be regarded as the chief means of obtaining the minimum amount of a working knowledge of surgery likely to satisfy official tests, and still less of equipping him for actual practice. But I regret to say that of late years it has become the custom for the hard-pressed student to desert orthodox clinical methods, and to consider as their equivalent, if not their superior, the cram-classes of the surgical coach.

## ON THE TREATMENT OF INTRACTABLE PROLAPSE BY EXTIRPATION

### OF THE UTERUS AND VAGINA. (a)

By CHRISTOPHER MARTIN, M.B., F.R.C.S.

EVERY gynaecologist 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. It was such a case that

led me in 1899 to devise and perform the operation of extirpation, not only of the uterus but also of the whole of the vaginal canal, as a radical cure. I have now carried out this proceeding in four cases. The final after result has been excellent, and the cure of the prolapse complete. It is, however, a very severe remedy. The operation is a long, tedious and bloody one, and attended with a good deal of shock. There is a considerable danger of wounding the bladder, the ureters and the rectum. Convalescence, in all my cases, was slow and complicated with suppuration in the depth of the pelvis. I should only, therefore, feel justified in recommending this operation in cases where other and milder measures have been tried and have failed, and where the patient's discomfort is very great. It is to be kept in reserve as a *dernier ressort* and not performed as a routine line of treatment. For obvious reasons it should not be performed in married or marriageable women.

I do not propose to discuss at length the treatment of ordinary prolapse. In a great majority of cases all that is required is a well-fitting pessary, and for marked procidentia I know of no instrument so satisfactory as Simpson's shelf pessary. When no pessary can be retained, or where the patient objects to its use, a plastic operation should be performed to support the uterus. In such cases I am in the habit of doing ventro-fixation of the uterus combined with an extensive colpoperineorrhaphy. The results, as a rule, are very satisfactory. Occasionally, however, it will be found that the uterus breaks away from the abdominal wall, or remains attached to it merely by a long thin band of adhesions, or becomes elongated and stretched, so that whilst the fundus is still adherent to the anterior abdominal wall, the cervix is outside the vulva. At the same time the vagina gradually dilates, the perineal scar stretches, and slowly the condition of total prolapse becomes re-established. In such cases vaginal hysterectomy may be performed. But whilst it is obvious that if the uterus be removed it can no longer be prolapsed, the operation does not cure the rectocele and cystocele. In one case in which I performed vaginal hysterectomy for prolapse, the vagina afterwards protruded as a large, polony-like swelling and turned completely inside out.

We may now pass on to a brief description of the object and the steps of the operation of extirpation of the uterus and vagina. The main aim of the operation is, after removal of the uterus and vagina, to bring together the fascia of the pelvis in such a way as to make a firm fibrous diaphragm extending from one side of the pelvis to the other, and having adherent to it the bladder in front and the rectum behind. In this way a firm, solid, pelvic floor is built up, measuring in depth from peritoneum to perinæum some three or four inches. We produce, in fact, a pelvic floor closely resembling that which obtains in the male pelvis.

In its broad outlines the operation closely resembles that of the radical cure of hernia. Thus the contents of the hernia are removed, the peritoneum is closed, the fascia is brought together with buried sutures, and finally the cutaneous wound is closed.

The patient should be kept in bed for several days before the operation, the functions of the stomach and the bowels regulated, and her general health

(a) Read at a meeting of the British Gynaecological Society, and specimen shown, October 18th, 1904.

improved as much as possible. The vagina should be rendered as aseptic as possible by frequent antiseptic douches. Should the prolapse be irreducible, the parts should be well washed with soap and water and lysol, swabbed with methylated spirit and then wrapped in gauze or lint soaked in a solution of biniodide of mercury. If, as is often the case, the cervix or vagina be ulcerated from friction against the patient's clothes, an attempt should be made before the operation to get the ulcers healed by keeping the patient in bed and applying antiseptic dressings. If any ulcers remain they should be swabbed with pure carbolic acid at the commencement of the operation.

The patient having been anæsthetised and placed in the lithotomy position, the vulva, the vagina and cervix are again thoroughly cleansed with lysol, followed by spirit and biniodide of mercury.

The cervix is seized with vulsella and drawn forwards. An incision is made in the mesial line through the vaginal mucous membrane from the posterior lip of the cervix to the edge of the perinæum. From the latter point two curved incisions are carried forward, one on either side at the junction of the vaginal mucous membrane and the skin of the labium, meeting in front about half an inch behind the meatus urinarius, that is, near the posterior edge of the vestibule. It will be seen that these incisions completely encircle the ostium vaginæ, and roughly correspond to the line of attachment of the hymen.

The mucous membrane of the posterior and lateral vaginal walls is now dissected off with scissors and turned forwards, but at this stage the mucous membrane of the anterior vaginal wall is not interfered with. The peritoneum of the pouch of Douglas is next opened by a transverse incision, and the fundus of the uterus exposed and drawn downwards. The broad ligaments are ligatured and divided from above downwards, either internal to or external to the ovaries and tubes. Should a ventro-fixation have previously been performed, the attachment of the fundus to the abdominal wall must be severed with scissors.

The fundus having been seized with forceps is drawn downwards, acutely retroflexing the uterus, and exposing the bottom of the utero-vesical pouch. The peritoneum at the bottom of this pouch is divided transversely and the bladder stripped off the cervix with the finger. The mucous membrane of the anterior vaginal wall is next dissected off the bladder and urethra with scissors and removed, together with the uterus, in one piece. This separation of the anterior vaginal wall is the most difficult and tedious part of the operation, and unless great care is exercised the bladder or ureters may be wounded. It usually causes free hæmorrhage from the veins of the vaginal plexus.

Each bleeding point must be seized and ligatured with fine silk or catgut. It is very important to control all hæmorrhage completely before proceeding with the next step of the operation. In every one of my cases there has been a collection of grumous pus, due, I think, to the breaking down of blood effused from these numerous small veins. All bleeding having been controlled, the abdominal cavity is closed by a purse-string suture of fine silk passed through the peritoneum of the pouch of Douglas, the back of the bladder, and the top of the broad ligaments.

Below this purse-string suture the broad ligament

of one side is sutured to that of the other with fine chromicised catgut. Below this the pelvic fascia of one side of the pelvis is sutured to that of the other side of the pelvis with fine interrupted chromicised catgut, beginning above at the base of the broad ligaments and working gradually down to just above the vulva. In this way a firm diaphragm, stretching from one side of the pelvis to the other and supporting the bladder in front and the rectum behind, is built up of connective tissue derived from the pelvic fascia. This is really the most important part of the operation. I do not attempt to suture the bladder or the rectum to this fascia. They afterwards become firmly attached to it.

The vulva and wound are then closed with fine silkworm-gut sutures which approximate the posterior halves of the labia.

If the hæmorrhage from the deeper part of the wound has not been completely arrested, I should recommend the insertion of two small rubber drainage-tubes, one in front of the fascial column and one behind it. These should be removed at the end of twenty-four hours.

The vulva is dusted with iodoform and a pad of iodoform gauze is applied. The patient's urine should be drawn off with a catheter for about a week, and she should be kept in bed for about three weeks.

As I have already said, 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. The prolapsed cervix and vagina are apt to be ulcerated from friction against the patient's clothes, and the discharge from these ulcers may lead to infection of the wound and suppuration. There is free hæmorrhage during the course of the operation, not so much from a few arterial trunks but from the numerous veins of the vaginal plexus. 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 old, feeble women 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. The after results, however, are excellent, and to my mind justify me in recommending this operation in suitable cases. Let me now very briefly refer to the four cases in which I have performed the operation.

CASE I.—Mrs. K., a widow, æt. 53, was sent to me by Dr. Leech, of Birmingham, suffering from stone in the bladder and complete prolapse of the uterus. She had evidently had the stone for a long time, and the straining which it gave rise to no doubt aggravated the prolapse. I took her into the Women's Hospital at Birmingham, and on July 22nd, 1895, removed a large calculus by the operation of vaginal cystotomy. The incision healed by the first intention. On August 16th in the same year, I performed the operation of ventro-fixation, together with perineorrhaphy. The wounds healed well, and the result was satisfactory for about two months. In November, 1895, she began again to have some cystocele, and I inserted a small pessary. Gradually the prolapse of the anterior and posterior vaginal walls recurred, and in spite of pessaries of all shapes and sizes became total. In October, 1896, the vaginal prolapse was so marked that I again took her into the hospital and performed extensive anterior and

posterior colporrhaphy together with perineorrhaphy. As before, the immediate result was satisfactory, but it was only for a time. In January, 1897, the cystocele recurred, and I had again to resort to pessaries. From this time onwards, she attended as an out-patient with steadily increasing prolapse until, in 1899, the uterus was once more quite outside the vulva, the vagina turned completely inside out and ulcerated from friction against the clothes. I then decided to perform total extirpation not only of the uterus, but of the whole vagina. I explained to the patient exactly what I proposed to do and she readily consented to have anything done that would afford her relief and enable her to carry on her work, that of a charwoman. The operation was performed on May 11th, 1899. The patient was put back to bed in a state of collapse, but rallied after free stimulation with ether, brandy, and strychnine. After this she continued to progress satisfactorily until about the tenth day, when her temperature began to show a marked evening rise and morning fall. This continued until the fourteenth day, when it reached 103° F. A pair of sinus forceps were then thrust into the depth of the vaginal wound, and a large collection of grumous pus (evidently broken down blood) evacuated. After this, she made a straightforward recovery, and left the hospital on the twenty-fourth day. After leaving the hospital she continued to improve, and when I saw her again, on June 30th, she was quite well. I examined her in the early part of July, 1901, and found her condition most satisfactory. She was perfectly comfortable, and had complete control of the bladder and rectum. The vulvar scar was firm and quite painless, and in her own words, "Life was now a pleasure instead of a continual misery." Since then I have seen her from time to time (the last occasion being October 10th, 1904). She has remained perfectly well and is very comfortable.

CASE II.—Mrs. J. L., æt. 56, was sent to me by Dr. Simpson, of Rugby, suffering from extreme prolapse. She was a widow and earned her living as a cook. She had had one child over thirty years ago. There was a history of gradually increasing prolapse for over twenty years. She had worn in turn instruments of various kinds (Hodge, ring, cup and stem, shelf, and Gariel's ball pessary). Finally, nothing would stay in, and she had to support the totally prolapsed uterus with a diaper. In June, 1901, she underwent a plastic operation on the perinæum at one of the London hospitals; but this gave only a very temporary benefit. On October 17th, 1901, I performed total extirpation of the uterus and vagina. For the first ten days the patient made a good recovery. Then her temperature began to go up at night to 101° or 102°, with morning remissions. Her pulse was never over ninety-five. I evacuated some pus with the sinus forceps on the fifteenth day. After this she did well and went home on November 19th, four and a half weeks after the operation.

I saw the patient on December 17th, and again in February, 1902. She could walk well, and go up and down stairs without any discomfort. There was no feeling of bearing down. She had no discharge and the bowels and the bladder acted normally. The vulvar wound was strong and firm, and showed no signs of bulging when she strained. She returned to her work as a cook and I hear has since remained well.

CASE III.—(Specimen).—Mrs. E. M., a widow, æt. 45, was sent to me by Dr. Baldwin, of Birmingham. The uterus was totally prolapsed and the cervix ulcerated. There was a constant discharge of blood and of muco-pus. Thirteen years before she had been operated on by another Birmingham surgeon, who repaired her perinæum. I found it impossible to insert any pessary, and the condition was so bad that I decided to extirpate her uterus and vagina. The operation was performed on November 22nd, 1902, when I removed her uterus, ovaries and tubes, and the whole of the vagina. The operation was performed in the method already described. The broad ligaments were ligatured with silk, the pelvic fascia sewn with chromicised catgut and the vulvar wound with silk-worm-gut. The patient did not make a good recovery. Her temperature went up the second day and fluctuated for some days between 99° and 102°. The deeper part of the wound became infected. Finally, a pair of sinus forceps were thrust in and a deep collection of pus evacuated. After this, she progressed quite satisfactorily, and left the hospital on December 28th, five weeks after the operation. The wound had then healed and all discharge had ceased. I saw nothing of her until April, 1903, when she came to the hospital complaining of discharge from the vulva. On examining her I found a deep sinus in the perinæum. I took her into hospital again and explored this sinus under chloroform, and was able to fish out some buried chromicised catgut sutures, which had become infected and had not been absorbed. After this, the sinus healed up and the patient's condition improved.

I last saw her about a week ago, and then found she had still a little discharge and that the vulvar cicatrix was red and irritable. Although she was infinitely better than she was before the operation, I suspect there is still a buried suture in the septum between the rectum and the bladder causing irritation. This case was the least satisfactory of the series.

CASE IV.—Mrs. J. L., a widow, æt. 63, was sent to me by Dr. Cowen, of Malvern. She had had prolapse for over twenty years. Many years ago Mr. Lawson Tait repaired her perinæum, but in about a couple of months the cicatrix stretched, and she was soon as bad as ever. She wore numerous instruments (such as rings, balls, cup and stem, and shelf pessaries), but nothing would keep in. During the last few months the parts have been badly ulcerated from friction. When I examined her I found the uterus totally prolapsed, and the vagina turned inside out and ulcerated. On February 29th, 1904, I performed total extirpation of the uterus and vagina, but did not remove the ovaries or tubes. The peritoneum and broad ligaments were sutured with fine silk, the pelvic fascia with gossamer-gut, and the vulva with silk-worm-gut. A small rubber drainage-tube was inserted into the posterior angle of the wound. It was a tedious and bloody operation and the patient was put back to bed rather collapsed, but rallied on free stimulation. Her temperature remained normal for the first fortnight. On the fifteenth day it rose to 100·6°, and two days later a free discharge of blood and pus took place from the wound. After this, she made a straightforward recovery; she got up on the twenty-third, and left the hospital on the twenty-sixth day after the operation.

I last saw her on April 25th, about two months after the operation. The wound was completely healed, she had no discharge, and no pain nor discomfort of any kind.

In relating the cases I have not attempted to minimise the dangers and drawbacks of the operation, and shall be glad of any suggestions or criticism from members of the Society which would improve the *technique*. In particular I shall welcome any suggestions which will help me to prevent the occurrence of the troublesome suppuration which complicated the convalescence of all my cases, and which, to my mind, is the chief disadvantage of the proceeding. I hope, however, in any future case to avoid this suppuration by more careful disinfection of the field of operation, by more careful arrest of hæmorrhage, by the use of drainage-tubes to prevent discharges collecting, and by the employment of perfectly sterile absorbable suture material.

Curiously enough, Dr. Edebohls, of New York, devised and performed an almost precisely similar operation in April, 1900, nearly twelve months after my first case. His description of the operation appeared in the *New York Medical Record*, on October 12th, 1901; while I published an account of my first operation in the *British Medical Journal* on October 5th, 1901, just one week before Dr. Edebohls. So that I feel that whatever merit there may be in the operation must be shared by Dr. Edebohls, who quite independently planned and carried out the same surgical operation.

### THE TREATMENT AND CLASSIFICATION OF PAUPER CONSUMPTIVES IN IRISH WORKHOUSES. (a)

By ALFRED E. BOYD, M.B., D.P.H.,  
Hon. Sec. of the National Association for the Prevention of Tuberculosis, Dublin Branch.

TUBERCULOSIS, a disease which is now known to be preventable, is still in Ireland the most common cause of death.

During 1902, the last year for which corrected figures are available, 11,837 persons died of this disease in Ireland as compared with 12,335 in 1901, and an average of 12,716 annually in the ten years 1891-1900. The death-rate for 1902 was 2.7 per 1,000 of the population as against 2.8 for 1901, and an annual average of 2.8 for the ten years 1891-1900. The highest county rates were—Dublin county borough, 4.7 per 1,000; Belfast county borough, 4.0; Dublin county, 3.5; Cork county and county borough, 3.0. The lowest were Cavan, 1.5; Roscommon, 1.6; Mayo, Fermanagh, Longford, and Donegal, each 1.7. The rate for all forms of tuberculous disease in the urban districts having a population of 10,000 and upwards was 4.1 per 1,000, while in the rural districts it was 2.1 per 1,000.

Speaking generally then, tuberculosis is a disease affecting urban rather than rural districts, and the eastern rather than the western counties of Ireland. Of the 11,837 deaths from tuberculosis registered in 1902, consumption, its commonest manifestation, caused 9,400 and of these 1,303 died in our workhouses. Half the total number of deaths in

all Ireland of those between 15 and 35 years of age are caused by consumption; the death-rate, therefore, is but a poor indication of the misery arising from this dread disease. In the words of Mr. Culverwell, Fellow of Trinity College, Dublin, "it is the adult, the wage earner, the man who has incurred the responsibilities of life, the man to whom a family looks for support, or the mother on whose care the welfare of young children depends, who are its most frequent victims." These are taken, often after a prolonged struggle, and those dependent on the victims are too often left without the means of support and become a burden to the rates. Again to quote Mr. Culverwell—"Assuming that on an average each of the 12,000 people who die annually in our country of tuberculosis is worth only 5s. a week to the community, and that he would live for ten years longer if there were no tuberculous germ in Ireland, then each death is a loss of over £130, and the total loss is 12,000 times this or £1,560,000 a year." (a)

Apart from all considerations of humanity and Christian charity, it is in the interest of everyone to do what in him lies to check this appalling wastage of national capital and to preserve to our country the flower of Irish manhood.

Patients suffering from this disease are now denied—and rightly so—admission to our general hospitals, because it is recognised that consumption is an infectious disease, a slow fever, conveyed from man to man, most usually by the inhalation of the dried expectoration of consumptives in the form of germ-infected dust, or of the spray scattered by consumptives in the act of coughing.

There are no sanatoriums in the country available for the very poor, although we hope soon to see at least two at work, in Cork and Belfast respectively, and were there such they would still leave the advanced cases, those, in fact, who are most dangerous to the community, unprovided for. The Homes for the Dying and Incurable can only accommodate a small proportion of such cases, the great majority must therefore perforce seek relief in the workhouse infirmaries or remain at home, usually sleeping in the same room, too often in the same bed, with their relatives, to whom their presence is a constant source of danger. No wonder, then, that consumption "runs in families" as the result of this constant exposure to the risks of infection in the home, and that the disease was deemed to be hereditary until its true nature was revealed by modern science.

In what direction, then, is reform needed in order that the Irish Poor-law system may deal adequately with its responsibilities in regard to this problem of the housing and classification of the consumptive poor? The first essential is that provision should be made in all workhouses for the complete isolation of consumptives from other patients, and for their classification—those in whose case there is prospect of amelioration or cure being separated from those in whom the disease is advanced and whose case is hopeless. In over one half of the unions in this country separate accommodation is now provided, and in this respect greater success seems to have been achieved by the Irish Local Government Board than by the kindred body in England, where the proportion of Boards doing anything in this matter

(a) Paper read at the Conference of the Irish Workhouse Association, held at Limerick, October 5th, 1904.

(a) "Consumption: its History and How to Prevent its Spread." E. P. Culverwell, F.T.C.D.



is said to be under 18 per cent. There still remains, however, the grave objection felt by so many of the respectable poor to availing themselves of treatment in workhouse infirmaries unless driven thither by dire poverty, and the consequent numbers of sufferers remaining in their homes and proving sources of infection to others.

In any scheme for the amalgamation of Poor-law unions, provision could surely be made for the setting apart of existing buildings, where such are suitable for the reception of consumptive patients, and for the remodelling of at least a portion of each building so set aside, so that it might be suited to the carrying out of open-air treatment in such cases as are likely to derive benefit from the method. The degrading associations of pauperism being removed, many who now regard the workhouse infirmary with abhorrence would gladly avail themselves of treatment under circumstances far more hygienic than they can command at home, while many of those who are beyond hope of cure would willingly submit to segregation for the sake of those dear to them, when the risks of their staying at home are made clear to them.

In many instances, however, existing buildings could not be satisfactorily adapted to suit modern open-air methods without considerable expenditure of money. In such circumstances I would venture to suggest that the method now being tried at the great Poor-law infirmary at Stobhill, Glasgow, might be followed. Advanced cases there are kept in isolated blocks, while suitable cases in the early stages of the disease, where the prospect of improvement is good, are treated in tents on the lawn of the infirmary. Each tent holds six beds and the patients pass all their time practically in the open air. The capital expenditure involved as regards these patients is trivial, and their cost to the ratepayers is merely that of maintenance. A similar method has been followed during the past few months at the Royal National Hospital for Consumption at Newcastle, co. Wicklow, as well as elsewhere. The results obtained have been hopeful and the patients soon get used to their outdoor life. This method seems to me to offer more prospect of efficiently treating great numbers of consumptive poor than can be achieved by any building scheme involving large capital outlay, while the delay which the erection of buildings entails is entirely obviated.

If, however, existing buildings are capable of being remodelled, and if the conditions as regards surroundings, subsoil, protection from prevailing winds and sufficiency of sunshine are favourable, French windows might be substituted for those at present in use, and these should be made to open on to light iron-work verandahs, or galleries on to which the patient's bed may be wheeled on suitable days at the discretion of the nurse in charge, acting on the instructions of the medical officer.

As an example of the cost of such alterations it may be mentioned that the Bath Board of Guardians have allocated two wards—for males and females—for the accommodation of twenty consumptives. These wards have been altered and made suitable for carrying out open-air treatment. They have separate airing courts in which are placed shelters and dining-rooms, so that those who can leave their beds may remain out in these courts practically all day. All this has been done for an initial expenditure of £1,900, which has been borrowed with the sanction of the Local Govern-

ment Board, repayment being spread over a period of ten years. (a)

Where no suitable buildings are available for treating cases with a view to cure, and if the idea of keeping patients in canvas tents is scouted as impracticable, resort must be had to building. All such schemes are costly; thus the Eastby Sanatorium of the Bradford Board of Guardians, which is built on the pavilion system, and which when finished is to accommodate 42 patients, will cost, it is estimated, £221 per bed.

The West Derby, Liverpool, and Toxteth Park Joint Poor-law Hospital for Consumption provides accommodation for 24 patients, the average cost per bed, exclusive of land, being £338. If, however, the number of beds is increased, the average cost of each will be materially reduced, as the administrative block has been included in the buildings already erected. (b)

Dr. Reinhardt estimates that a sanatorium built on the chalet principle to accommodate 100 patients can be erected at an average cost of £100 per bed. (c) Speaking generally, the most feasible scheme seems to be the amalgamation of Unions, the setting free of one set of buildings for the use of consumptives of the joined area, the separation of the incurable from those in the early stages of the disease, and the treatment of the latter in wards adapted to open-air requirements, in tents or in open-air revolving shelters as each individual case may seem most suited to. The initial cost of such a scheme need not necessarily be great, while in the long run its provision would be true economy in preserving life among those already consumptive and in preventing the spread of the disease among the community. Without some such scheme how can the poor be treated with any reasonable hope of arresting the disease? And how can they be kept from being factors in the spread of infection?

The isolation of consumptives and their treatment under special conditions removes from the community the chief source of the spread of the disease, while the educational effect on the public of the means taken in well-managed institutions to prevent infection must have a wide-spread influence in checking its development.

In conclusion, let me remind you that this disease is one of the two great causes of the decrease of the population of our country.

We lose 40,000 each year by emigration, and 12,000 from tuberculosis. Those who are lost to the country from both causes belong to the same class—they are those in early adult life. There are factors at work in the industrial life of our country, which we all hope will have an influence in checking the national loss arising from emigration.

May I express the hope that the other great source of the decrease, the prevalence of tuberculosis, arising as it does in great measure from neglect and ignorance in bygone years, may receive that attention from our public bodies which it deserves and that the means by which its prevalence is being decreased in other lands may soon be adopted throughout our country? If our boards of guardians and sanitary authorities work hand in hand, if they act promptly and energetically, the death-rate from this cause can be materially

(a) "Boards of Guardians and the Crusade against Consumption." L. A. Weatherly, M.D. "Tuberculosis," April, 1904.

(b) *Ibid.*

(c) "The Health Resort," October, 1903.

reduced, and a corresponding decrease in misery and pauperism will ensue.

### Clinical Records.

#### CANCEROUS UTERUS REMOVED BY COMBINED VAGINAL AND ABDOMINAL HYSTERECTOMY. (a)

By WILLIAM DUNCAN, M.D., F.R.C.S.

THE uterus shown was removed from an exceedingly stout nulliparous lady, *æt.* 42, who consulted Dr. Duncan in July last for menorrhagia, which had lasted four months. She had been twice married; fifteen years ago she consulted Dr. Duncan for the same condition, when the uterus was dilated and curetted. A mucous polypus was removed and a complete cure resulted. On examination *per vaginam*, the vagina was very small; cervix uteri healthy; sound passed 3½ inches, and caused bleeding (the patient was so stout that a bimanual examination was not possible). She looked healthy and well, and suffered no pain or offensive discharge. On dilatation of the uterus under anaesthesia, the curette brought away a lot of cheesy material; this was examined by Mr. Targett, who reported: "These curettings from the interior of the uterus are thickly infiltrated with a soft columnar-celled carcinoma of the villous type." A week later Dr. Duncan removed the uterus by hysterectomy, and as the vagina was so very small and the patient so stout, he adopted the combined method. When anaesthetised the patient was placed in the lithotomy position and an incision made all round the cervix; the bladder was separated up, and Douglas's pouch opened. Next the abdomen was opened, and the uterus removed in the usual way, but with the greatest difficulty owing to the excessive thickness of the abdominal walls and also to the fact that the broad ligaments were very short and did not allow the uterus to be pulled up much. The patient had a normal temperature on the eighth day. Dr. Duncan thought that perhaps it would have been easier to have cut through the perinæum to the anus and then have performed vaginal hysterectomy (as he has done on other occasions) rather than to have adopted the combined method.

#### CYST OF THE RIGHT FALLOPIAN TUBE (? ECTOPIC GESTATION). — DOUBLE TWIST IN THE PEDICLE AND COMMENCING NECROSIS OF CYST WALL. (a)

By BEDFORD FENWICK, M.D.,  
Physician to the Hospital for Women, Soho Square.

THE patient was *æt.* 46, unmarried. Menstruation commenced at 14, and has been perfectly regular every twenty-four days, lasting three days, and otherwise quite normal. She came to the Out-Patient Department of the Hospital for Women, Soho Square, on October 6th, stating that in August last the period was fifteen days late, lasted four days, and was very scanty, ceasing on September 5th, since which time she had seen nothing. On September 30th, she had a sudden, severe pain in the lower part of the abdomen, lasting three or four hours, and gradually passing off. On the morning of October 6th, the same pain suddenly returned and became very severe. On examination, the vagina was found to be large and

(a) Read at a meeting of the British Gynaecological Society, and specimen shown, October 18th, 1904.

lax, a tense swelling was felt in front of the uterus, fixed and extremely tender. Her temperature was 103° F., pulse, 110. She seemed very ill, and was at once sent into the wards, and I performed abdominal section the next day. The uterus was pushed down into the pelvis by a cystic swelling, thick-walled and perfectly black in colour; it was attached by soft recent adhesions to the bladder in front and the uterus behind. A pint of black blood was drawn off from it, and the cyst lifted out of the abdomen, and it was then found to have a long pedicle, twice twisted. On removal, a small, black ovary was found adherent to the outer edge of the cyst wall, and the cyst itself was found to be a dilatation of the outer third of the right Fallopian tube. There was no rupture, but there was commencing peritonitis. The left tube and ovary were perfectly normal. The sac seems lined with membrane, and contains apparently some firm, organised clots; but as it may be the wish of the Society to refer the specimens to a pathological committee, I have not disturbed these in any way. It will be observed that the tube is extremely constricted about one inch from the cornu of the uterus, where the double twist was found, and the surface of the cyst is perfectly black, and shows signs of commencing sloughing of its wall.

The important question arises as to whether this is a simple hæmato-salpinx or an ectopic gestation. In favour of the latter, is the dilated condition of the vagina, the definite and large dilatation of the outer third only of the tube, not of its whole length, and the considerable quantity—at least one pint—of blood which it contained. Presuming that further investigation proves this supposition to be correct, I need scarcely point out the rarity of the case. I can only remember having seen one similar example, and it must, therefore, be most unusual. It is further interesting to observe the rapidity with which necrosis and peritonitis were being induced, and the extreme danger which the patient would have suffered if she had not been immediately operated upon. She made an uneventful recovery.

### Transactions of Societies.

#### BRITISH GYNECOLOGICAL SOCIETY.

MEETING HELD OCTOBER 13TH, 1904.

Professor JOHN W. TAYLOR, F.R.C.S., in the Chair.

#### SPECIMENS.

DR. BEDFORD FENWICK showed as a strangulated ectopic gestation a necrotic sac removed from a single woman, *æt.* 46. The operation had been performed under the diagnosis of ovarian cyst, though certain points in the history pointed to extra-uterine gestation. He had met with one very similar case, and as he thought the Society might wish to refer the specimen for an independent pathological report, he had not himself made any section of the sac. Notes of the case will be found on this page ("Clinical Records").

After some remarks from Dr. DAUBER and the PRESIDENT, it was agreed that the specimen should be referred to a pathological committee.

Dr. FREDERICK EDGE showed the following specimens:—(1) Microscopical section from a case of glandular carcinoma of both ovaries removed with perfect immediate result, but with fatal recurrence within four months. The patient was *æt.* 48, and, apart from the tumours, was in good health and condition. The operation was performed at the Women's Hospital, Birmingham, on May 26th, 1904. The tumour on the

right side extended to the liver, and was of peculiar shape, resembling a vegetable marrow with one side pushed into concavity; the pedicle on this side was broad and fleshy, no doubt owing to increase in the muscular tissue of the broad ligament, and he therefore divided it and secured the vessels separately. The other tumour was much smaller and was tied straight off. Any adhesions were omental and all bleeding points were secured; no drainage was used, and the patient made an easy and uninterrupted recovery. On August 17th, in Dr. Edge's absence, the woman was readmitted into the hospital by his colleague, Mr. Furneaux Jordan, on account of pain and intestinal obstruction, but as this was found to be incomplete and intermittent, the abdomen was not opened. Large masses of growth could be felt in the pelvis and omentum; these rapidly increased and she died on September 7th, three weeks after her readmission, that is, within three and a half months of the ovariectomy. The section, which was prepared by Dr. Smallwood Savage, showed that the tumours were glandular carcinoma.

(2) A large, many-lobed myomatous uterus successfully removed by supravaginal hysterectomy. The patient was a small, thin woman, *æt.* 42, and the operation had been performed on account of pain, symptoms of pressure on the bladder and bowels, and enlargement of the growth. The lobular masses ran under the peritoneum in several directions and were enucleated from their beds. The peritoneum and floor of the pelvis were injured to such an extent that the abdominal cavity could not be closed by a complete transverse suture, and as the extensive opening up had led to free oozing, Dr. Edge thought it better to open the vagina and drain. During the following night there was sudden and very severe hæmorrhage, and it seemed that he would have to reopen the abdomen. Fortunately the bleeding ceased and did not recur, and there was no other disturbing symptom. Though there had been such extensive laceration of the tissues, there was no fever, and this absence of reaction after such severe surgical wounds he attributed to the use of antiseptically impregnated sutures and the prevention of the so-called "implantation infection" more than to any other factor. His silk sutures are boiled in solution of corrosive sublimate or of biniodide of mercury, and used straight out of the solution; silkworm-gut is treated in the same way; catgut is boiled in xylol, preserved in alcohol and corrosive sublimate (1 : 1,000) and used out of the preserving medium. Even if the outer surface of the ligature or suture be soiled by the hand, the antiseptic material is afterwards given off by them and kills the germs or inhibits their infective action until the normal currents are re-established and the phagocytic agents are able to destroy the micro-organisms.

Mrs. SCHARLIEB mentioned a case similar to the one first related by Dr. Edge. She removed two solid malignant ovarian growths with thin, ordinary pedicles, and had no reason to suppose that the operation was in any way incomplete, but the woman died about six months later from a secondary growth affecting the transverse colon.

Mr. FURNEAUX JORDAN said that when, in the absence of Dr. Edge, he was called to the case, he expected to have to operate for intestinal obstruction, but by the aid of injections the bowels were freely relieved and he could then feel a small lump behind the cervix. As the only history he had was that the tumour removed was a solid ovarian one, and he had no hint of its malignant nature, and as the obstruction had been relieved, he did not interfere, and in a few days was glad he had abstained from doing so, for in those few days the growth had increased so rapidly in size that it rose right out of the pelvis and could be felt in the abdominal wall.

Dr. EDGE said that it would have been natural for Mr. Jordan to suppose that after such a recent operation the obstruction was due to intestinal adhesion to the stump or pedicle. A fatal termination from the

recurrence of such a malignant growth within three and a half months after a complete operation had not, so far as he knew, been previously recorded.

Mr. J. FURNEAUX JORDAN showed:—

1. *Double Tuberculous Pyosalpinx*.—A. H., *æt.* 21, single; general health good. For some four months had indefinite pain in the lower part of the abdomen, but did not think it was anything serious. One day, when having her bath, felt a lump in the lower left part of the abdomen. The pain becoming worse, she went to her doctor, who asked me to see her. On examining her I could feel the top of two distinct swellings above the pelvic brim. Since, apart from the pain, she complained of nothing and there was no interference with her general good health, I thought it was an ovarian cyst. It was two or three weeks before I could admit her into the Women's Hospital, and by that time the pain had become very severe. On April 19th last I removed by abdominal section the two tubes you see here, the larger one from the right side. A few tubercles were dotted about the peritoneum of the broad ligament. One ovary, quite free from tubercle, I left alone; the other I removed. The patient now, six months after the operation, is in excellent health.

2. *Cystoma of Left Ovary*.—Mrs. H., *æt.* 28, was four months pregnant and complained of excessively frequent micturition and constant bearing down pain. On examination I found the uterus pushed up into the abdomen and the pelvis completely filled by a tense, elastic tumour. On May 8th last, I operated at the Midland Nursing Home by the vaginal route, and through a small incision into Douglas's pouch I tapped the cyst, pulled it out, and ligatured the pedicle. The cyst was a good bit larger than it appears to be, the walls being stretched and thinned. Fortunately there were no adhesions. Pregnancy was uninterrupted.

Mr. JORDAN said that he was not now so keen on the vaginal route for operating as formerly; but this case of the removal of a cystoma from a pregnant woman without any interruption of the pregnancy showed that there were cases in which the vaginal way had very great advantages and should certainly be chosen.

Dr. WILLIAM DUNCAN said that tuberculous pyosalpinx was met with in some women who appeared to be the picture of health, and it was remarkable how well such cases did even though, at the time of the operation, they might seem to be most unfavourable, and the whole of the peritoneum might be studded with millet-seed tubercle. He instanced a case in his own practice which afforded a typical specimen of double tuberculous pyosalpinx, now in the museum of the Middlesex Hospital, both tubes being distended with cheesy pus. Five years after the operation the patient was in perfect health. Tumours complicating pregnancy were always of very great interest, and when ovarian should invariably be removed at whatever period of the pregnancy they might be detected. But he must join issue with Mr. Jordan as to the vaginal route, for he thought the abdominal route should always be chosen. He would be sorry to open the vaginal vault, hoping, but by no means sure, that there were not adhesions that might make the removal of the tumour difficult or impossible. As a good example of the superiority of the abdominal route and of the tolerance of the womb, even during labour, to surgical proceedings, he mentioned that in a young married woman in whom a contracted pelvis was suspected, he found not only a pelvis *justo minor*, but a hard tumour fixed to the sacrum, which would have prevented delivery by the natural way. At term, labour having begun, he opened the abdomen, and determined to try and remove the tumour before deciding to open the womb; he extended the incision to the ensiform cartilage, drew out the uterus, and was then able, with much difficulty, to remove the sacral tumour, a dermoid. He returned the uterus to the abdomen and closed the wound at ten in the morning; the patient was delivered by forceps at two o'clock

the same afternoon, and made a perfect recovery without any rise of temperature.

Dr. MACNAUGHTON-JONES said that it was not uncommon to have absence of pain in pyosalpinx, and instanced some cases in which this immunity was present, notably one he had recorded at the Obstetrical Society, in which there was a large double pyosalpinx. The pelvis was filled by a large effusion containing two pus sacs, and the bladder was distended from pressure. The patient had never complained of pain, and the symptom for which she sought relief was incontinence of urine. He had brought a case of tuberculous salpingitis before the Society three years ago, which was unilateral, and the sac similar to one of those shown by Mr. Jordan. It was primary tuberculosis, and the lady had since had two pregnancies, one of which was a twin birth. The lesson to be learned from these cases was that the risk entailed by the non-removal of such pus sacs was very serious. As to the second specimen, the choice of operation for ovarian cystoma by the vagina would depend upon the diagnosis, the unilocular nature of the cyst, and the absence of adhesions. Given accuracy of diagnosis on these points, there could be then no doubt that the vaginal route would be the preferable one, but such diagnosis was sometimes extremely difficult. Operation on ovarian cystoma in pregnancy was now the accepted rule, but the time of selection was from the end of the second to the fourth month.

Dr. BEDFORD FENWICK said that the case of tuberculous tubes shown by Mr. Jordan was one in which he felt the greatest interest because, apart from the excellent results obtained by Mr. Jordan, the case opened up a very large and important question. He had operated on a considerable number of these patients, and with results which had more and more impressed him with the advisability of early operation in all cases of pelvic disease which appeared to be tuberculous in character. Most abdominal surgeons had met with cases of tuberculous peritonitis in which the mere opening of the peritoneal cavity, even if nothing else was done, had been followed by the disappearance of the peritoneal mischief and more or less rapid improvement in the patient's health. But it almost appeared as if the logical lesson of that fact had not been entirely appreciated; his experience compelled him to believe that there were a large number of cases of tuberculous disease in women, which originated in the ovaries or tubes; and that the early removal of the primary disease, even if secondary mischief had appeared, must be productive of some good, and might even lead to cure. At any rate, he had seen a number of cases in which the latter event had occurred, and might mention one excellent illustration of it. A woman, *æt.* about 33, had been admitted into his wards for ovarian and tubal disease and general peritonitis. It was evidently tuberculous in character, and the apices of both lungs contained cavities, whilst the patient was reduced to a state of extreme emaciation and exhaustion. Before operating, he pointed out that his hope in these cases was by removing the original source of disease to prevent further general infection, and certainly to cure the tuberculous peritonitis, and assist the patient in fighting against the pulmonary extension. In that case, both ovaries and tubes were found to be extremely diseased, and the whole pelvic contents matted together, whilst the intestines and peritoneum were thickly studded with miliary tubercles. He removed the diseased appendages. The peritonitis completely cleared up, the lungs commenced to improve at once, and when she left the hospital she had gained more than a stone in weight, and the pulmonary cavities were healing. Some months afterwards, when she reported herself, her general condition was excellent in every way. It was almost needless to say that equally good results could not always be obtained. When, for example, the lumbar or thoracic glands had become infiltrated, so that secondary foci of infection had developed, one could not hope for complete cure, but as it must take

some time for secondary developments, he was convinced that early operation afforded the best ground for hope that a complete cure might be effected, and that it was not only common sense and surgical science in these, as in every other case, to remove as speedily as possible the *fons et origo mali*, but that, in these cases of tuberculous pelvic disease, there was a great possibility, by early operation, not only of removing the local disease from which the patient suffered, but also of saving her from the gravest secondary developments.

Dr. E. TENNISON COLLINS agreed with Dr. Macnaughton-Jones that if in diagnosis one could be sure that the cyst was unilocular and non-adherent, operating by the vaginal route was both simple and rapid. He recalled two cases of his own, in one the cyst was large, and in the other, though not so, it was rapidly increasing in size; in each case he opened the abdomen by a small incision, both went on to term, and did well. As it turned out there were no adhesions in either case. He was glad to hear Dr. Duncan speak so emphatically in favour of the abdominal route.

Dr. EDGE remarked that though much of his experience accorded with that of Dr. Bedford Fenwick, he could not be so enthusiastic about the effect of removing tuberculous appendages upon tuberculous lesions already present in the lungs. On the whole the results of his operations had been favourable, but by no means so brilliant as described that evening. For instance, after an operation of the kind last summer, the wound healed well, and all seemed satisfactory for a fortnight, when, suddenly, the patient's mental condition changed, miliary tuberculosis set in, and she died in a fortnight. There was, it is true, an abscess cavity in the lung.

The PRESIDENT said that he entirely agreed with Dr. Edge. Nor very long ago, after a difficult operation for the removal of a tuberculous pyosalpinx, he obtained a comparatively good result for two or three weeks, but the patient afterwards succumbed to tuberculous meningitis. With regard to operating by the vaginal route in pregnancy: A tumour in pregnancy which gave distinct evidence of fluctuation, and of being a cyst, and not a dermoid, was very rarely adherent; and it was infinitely better to attack it by the vagina, especially if the cyst was blocking the pelvis below the pregnancy. In a case very similar to Mr. Jordan's, which he brought before the Obstetrical Society some years ago, the operation was a small one, the cyst could be quite easily removed, there was no abdominal wound, and the pregnancy was not interfered with at all. In such cases he considered the vaginal route ideal.

Mr. FURNEAUX JORDAN, in reply, said that the President had to a great extent answered all that had been advanced against operating by the vagina. Dr. Duncan, however, seemed to think that if the cyst had been adherent he (Mr. Jordan) would have been in a serious difficulty, and in this he could not agree. He could have proceeded at once to operate from the abdomen and the patient would have been none the worse for the small opening that had been made in the vaginal vault. The case was an excellent illustration of the fact that, as the President had said, when there were no adhesions and the tumour was below the pregnancy, the vaginal route was the right one. To say or infer that he would adopt the vaginal route in every case would be absurd. The President and Dr. Edge had also answered some of the remarks that had been made as to the effects of operations for pelvic tuberculosis. The benefit upon tuberculous peritonitis of merely opening the abdomen was well known, but, as regards the wider operation for the removal of tuberculous pyosalpinx, it was most difficult to give any prognosis, especially where there was general peritonitis and extensive deposits in the mesentery. One case would get well and perhaps the next, apparently quite similar, would not. One could not say why, but only hope for success knowing the best had been done.

Dr. WILLIAM DUNCAN showed a specimen of cancer

of the body of the uterus, and read notes of the case, which will be found on page 434.

Mr. BOWREMAN JESSETT did not understand why a combined vaginal and abdominal operation should have been required; a uterus of the size shown was, in his opinion, comparatively easy to remove by the vagina. Of course, in very fat women there was more difficulty, but that could be overcome by making a deep incision on one or even both sides of the rectum through the perineum and para-vaginal tissue, extending to the fornix. He had practised this method for several years, and believed he adopted it before it came to be known on the Continent as Schuchardt's incision.

Dr. HEYWOOD SMITH said that in the hands of one accustomed to use it the sound would give information of any tortuosity of the canal or roughness of the internal surface of the uterus; if it were possible to diagnose malignant disease in that way it might be better to remove the uterus at once without curetting.

Dr. F. A. PURCELL said that at the Cancer Hospital, where they had to remove many uteri, they had found that in a patient such as Dr. Duncan had described, the abdominal route was practically out of the question. With the aid of the incisions Mr. Jessett had described, and which Mr. Jessett and he himself had developed independently, ample room could be got to secure the broad ligaments and bring down the uterus.

Dr. MACNAUGHTON-JONES said that he could not agree with Dr. Purcell's remarks as to the removal by the abdominal route being out of the question in any case of uterine cancer. Wertheim, v. Rosthorn, and a considerable proportion of the most distinguished gynaecologists operated by the abdomen in all cases, though a large number of men of equally high reputation thought the best results were to be hoped for from early vaginal extirpation. The contrast in practice had been well reviewed by Olshausen, at Oxford, quite recently.

Mr. CHARLES RYALL said that in some cases in which vaginal hysterectomy seemed almost impossible, it was found that the abdominal operation was not any easier. For the patient's sake, the best operation was the quickest, and where time was the object he would pull down the uterus, and having opened the anterior and posterior fornices, would split it, and, to avoid the loss of half an hour in trying to get ligatures on the broad ligaments, would apply forceps.

Dr. J. J. MACAN asked whether anyone would now seriously advocate the bisection of the body of a cancerous uterus.

Dr. HERBERT SNOW asked for the grounds upon which Dr. Duncan had based his diagnosis, and what were the clinical symptoms. He thought the use of the sound unnecessary and undesirable for the diagnosis of uterine cancer.

Dr. EDGE asked Dr. Duncan what degree of elevation he was able to obtain. It seemed hardly possible for any woman to be so stout that, with full elevation and complete retraction, one would not have a better attack on the fundus from the abdomen than by any vaginal route.

Dr. DUNCAN, in reply, pointed out that he had laid much stress upon the extreme narrowness of the vagina of this patient as the reason in the first place why he had not undertaken a vaginal operation, which he agreed with Mr. Jessett to be the way of best attacking a cancerous uterus. In answer to Dr. Snow, he said that he used the sound because, owing to the woman's obesity, it was impossible to ascertain the size of her womb by bimanual palpation. There were no clinical symptoms pointing to malignant disease, but as he had mentioned, Mr. Targett had made a report upon the microscopical examination of scrapings from the cavity, and he had no doubt as to the diagnosis. He hardly ever made use of the sound, either for diagnosis or treatment, and naturally would not have done so had he had reason to suppose that there was cancer of the fundus. Time was no doubt most important, and more than an hour taken over an abdominal operation certainly militated against the patient's

recovery, but, as long as the time did not exceed an hour, he thought it did not much matter. He felt sure that Mr. Ryall would not advocate the bisection of a cancerous uterus if he had had the same unfortunate results from forceps that had occurred to himself, and would give up forceps in favour of ligatures. Replying to Dr. Edge: He was not able to obtain satisfactory elevation as the operation took place at the patient's house, and no table suitable for the Trendelenberg position was to be had.

Mr. RYALL said that he would prefer bisecting even a cancerous uterus to leaving it behind unremoved. With regard to Dr. Duncan's remarks about forceps: these, when applied to blood-vessels, did not act like a string tied round an indiarubber water tube, but, by causing stasis, led to the coagulation of the blood in the vessels, and when coagulation had occurred there was no reason, if ordinary care was employed, why they might not be taken off without any hæmorrhage. They had been successfully used by gynaecologists in thousands of cases.

Dr. MACNAUGHTON-JONES showed "Two Microscopic Sections": the first from a Case of Hystero-salpingo-oöphorectomy for Hæmorrhagic Endometritis due to Glandular Endometritis, and said that the case was interesting more from a clinical and pathological than from an operative point of view. The differentiation of the various forms of hæmorrhagic endometritis included therein was another matter, and a most difficult one. He hoped on a future occasion to indicate the histological differentiation of the various forms of endometritis which lead up to what is called hæmorrhagic endometritis. In addition to the specimen shown there was another on the table which he had shown at the Society before; he had brought that uterus and adnexa that it might be compared with his own specimen. Here the adnexa of one side had been first removed, and subsequently those of the other, for cystic disease; finally, the uterus, for hæmorrhagic endometritis. The patient was now perfectly well. The pathological report was that the adenomatous change was extending from the endometrium into the substance of the uterus. In the case now before the Society for the first time, the patient, who consulted him in November, 1902, was in her 43rd year, and was over six feet in height. She had cardiac complications, and was completely blanched from constant hæmorrhage. After a month's rest she was curetted, and the report stated that there was nothing malignant, and only some slight glandular changes in the endometrium. Her health improved, and the hæmorrhage ceased for a time. It recurred later, and she consulted him again in April of the present year. She was again curetted. The report then furnished to him by Dr. Cuthbert Lockyer was that the endometrium presented large round-celled infiltration of the stroma, the tubules having in many instances become distended into small cysts. A few of these were large enough to be distinguished by the naked eye. The curettings were under the microscope, and the changes described by Dr. Lockyer were quite evident. After a brief respite, the patient again suffered from recurrence of the hæmorrhage, and in August he performed complete salpingo-oöphorectomy, from which she completely recovered. There was an interesting point with regard to the specimen. After removing the uterus he split and cut up either cornu in the usual fashion, and out of one exuded what appeared to be pus, to the extent of about one and a half teaspoonfuls. He thought it was a case of suppurating endometritis, but a further examination showed that it was not pus. An abstract of the histological report is of interest:—The uterus has been slit open towards the left cornu, as directed, and sections cut in this situation. They reveal a healthy fibro-muscular wall, but a thickened endometrium covered by a pultaceous deposit consisting of epithelial debris. The endometrium shows two pathological changes, advancing *pari passu*, viz.: interstitial fibrosis and desquamation of the gland tubules, both changes being well marked.

There was no sign of an abscess cavity. The extreme desquamation of the glands amply accounts for the mass of shed epithelium and *débris*, which looked not unlike true pus. The wall of the uterus at its thickest part measures one inch. There is a small circular fibroid the size of a marble in the left uterine wall, just above the line of amputation. The right ovary was cystic the left also; two small blood cysts and both tubes showed evidence of chronic salpingitis.

The second was a rather unique specimen, which he had brought from Bonn that week, from Professor Schroeder, assistant to Professor Fritsch, of that University. It was the section of an ovary from a still-born child dying in birth, and showed typical commencing ovarian cystoma.

Owing to the lateness of the hour these specimens were not discussed.

Mr. CHRISTOPHER MARTIN then read a paper on "The Treatment of Severe Prolapse by Extirpation of the Uterus and Vagina," which will be found on page 429.

The discussion of this paper was postponed.

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, October 23rd, 1904.

#### TREATMENT OF ARTERIO-SCLEROSIS.

THE name of arterio-sclerosis is given, says Dr. Debrive, to a chronic affection of the small arteries, whose walls are invaded by sclerous tissue. These lesions are habitually generalised and attack the arterioles of the viscera—liver, kidneys, brain, heart, &c.—producing in those organs anatomical and functional troubles, giving to the disease its particular character.

The cause of arterio-sclerosis is very varied—arthritis, gout, chronic rheumatism, obesity, diabetes. Besides these, certain infectious maladies, as typhoid fever, syphilis, paludism, &c., can modify the arterial walls by their effect on the blood and produce sclerosis in time. Slow and prolonged poisoning of the blood is one of the most powerful factors in the production of the disease. Saturnism, smoking, and alcoholism have been incriminated. The same may be said of physical and mental strain (*surmenage*).

Besides these etiological conditions, age, with the progressive waste of the tissues resulting from the wear and tear of the organism and the incomplete elimination of the waste, is capable of producing alone arterio-sclerosis. Very few aged persons or even younger adults are exempt. The male sex is much more frequently attacked than the female sex; and heredity plays a certain *role*. For Professor Huchard the mode of action of the causes of arterio-sclerosis is arterial hypertension gradually provoking vascular irritation, ending in sclerosis. The internal tunic of the small arteries is thickened, with tendency to obliteration, and the troubles of the circulation resulting from the lesions can provoke gangrene or necrosis.

In its initial period, arterio-sclerosis presents no signs of precise location. The patient complains of manifold troubles, dyspnoea in walking, or on slight efforts, accompanied by a disagreeable sensation of constriction in the thorax. The digestion is laborious; after the repast, the face, generally pale, becomes coloured, and at the same time he complains of palpitations and a tendency to sleep. The temporal arteries generally regular, pulsate violently. The pulse is regular but rather strong (and rapid; the arteries are hard. Auscultation of the heart reveals a loud dyostatic sound at the aortic orifice, the other sounds are also sharp and regular; the organ is generally hypertrophied. The urine is abundant and limp.

Such are the symptoms of arterio-sclerosis at its commencement. Progressively these different manifestations of the malady finish by predominating in a vascular territory. Of all the organs, the kidney is the most frequently affected, after which comes the heart, and finally the brain.

The renal type of arterio-sclerosis develops insidiously without any other manifestation than that of arterial hypertension. It is characterised anatomically by interstitial nephritis. Clinically, polyuria is observed, slight albuminuria, palpitations with a *bruit de galop*. Patients affected with arterio-sclerosis succumb frequently to nephritis, heart disease, hæmorrhage, or softening of the brain. Consequently the prognosis is generally grave, although it varies with each particular case; renal or cardiac insufficiency renders it very sombre.

#### THE TREATMENT OF ARTERIO-SCLEROSIS.

The treatment consists of two parts: hygienic and medical. The quantity of aliments should be reduced to a simple sufficiency. Meat, the principal cause of alimentary intoxication, should be consumed with the greatest moderation. Game, pork, salt meats, should be proscribed, as well as fish, preserved meat, asparagus, tomatoes, mushrooms. Milk should be the exclusive diet where the patient complains of oppression, headache or insomnia. As regards liquids, water is the best, but a little white wine well diluted with water may be given at meals if the patient desires it. The only therapeutic agent which appears to act beneficially in retarding the evolution of arterio-sclerosis is iodide of potassium. It should be given in small doses, from 5 to 10 grains, daily for a long time, twenty days a month; and continued for a year or more. Trinitrin is recommended where dyspnoea or vertigo exists, in the dose of 2 drops morning and evening of the 1 per cent. solution. As soon as the heart gives signs of weakness, strophanthus or spartein may be ordered, but digitalis is counter-indicated as long as hypertension exists; it will be reserved for the period of œdema.

Trunczek, of Prague, has invented a serum, of which the following is the composition, to supply the salts wanting in the blood in arterio-sclerosis, and which seems to have given some good results in the initial period:—

Sulphate of soda, 0'44 centigr.;  
Chloride of sodium, 4'92 centigr.;  
Phosphate of soda, 0'15 centigr.;  
Carbonate of soda, 0'21 centigr.;  
Sulphate of potash, 0'40 centigr.;  
Water, 100 grammes.

He injects under the skin from 1 to 7 centimetre cubes.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 22nd, 1904.

#### FURTHER DISCUSSION ON LIGHT TREATMENTS.

At the International Dermatological Congress, Hr. Freund (Vienna) reported his experiments, in conjunction with Oppenheim, as to measuring the action of the Röntgen rays. Gaucher and Werther had seen inflammation of the kidneys after Röntgen treatment. Buschki and Schmidt (Berlin) had come to the following conclusions: (1) It was possible to cause deeper layers of epithelium to disappear without severe changes in the overlying skin. (2) Necrosis and also molecular destruction in the sense of simple atrophy could be wrought about in the epithelium of glandular organs by the Röntgen rays. (3) Under suitable conditions



change or a suppression of function in a gland could be brought about by them without any grave anatomical changes.

Hr. Schlotz (Königsberg) related the results of his experiments on the action of concentrated lights. The action of the Finzen light, he said, did not depend alone on the action of the very frangible ultra-violet and blue-violet rays, which by their absorption brought about actual chemical action (chemically active rays), but also on the action of the lesser frangible rays, which caused warmth by their absorption. A portion of the chemically active rays might even penetrate deeper layers of tissue; the physiological effect of these rays was but small, however. The physiological action of these chemically active rays diminished rapidly, therefore, in the deeper tissues. The heat rays had a greater penetrating power, and their action on the superficial layers could be governed at will by cooling apparatus. It might easily be that the effect of the heat rays as regarded deeper structures did not diminish, but, on the contrary, increased. The intensity of the action of light rays on the different parts of the skin naturally depended on the rate of absorption, and as the diseased tissues of lupus were darker in colour than the normal skin, and in consequence of this the rate of absorption would be greater in the diseased than in the normal tissue, so the rays of light would act electively on the lupoid tissues. On this probably depended the favourable action of light in the treatment of lupus. The action of the whole of the light rays might be heightened by suitable colouring of the deeper layers of skin, but the procedure of colouring would be of little use in the case of lupus as the light already acted electively.

In a discussion on radium treatment, the same speaker summarised his conclusions as follows:—The physiological action of the rays from radium on the whole resembled that from the Röntgen rays. It differed from it, however, in the following: The radium rays had a greater effect on the vessels; they had a more powerful, deep action, and they had a not inconsiderable bactericidal action. From a therapeutical point of view the action of the radium rays was, on the whole, similar to that of the Röntgen rays. The action of the radium rays was more energetic than that of the Röntgen rays in the following: The radium rays acted more powerfully and more favourably in malignant new growths of the skin, especially carcinomata. The radium rays acted better in telangiectases and small angiomas. Above all, the radium rays could easily be applied in many parts of the body, and especially in cavities, where the Röntgen rays could not be applied.

The *Deutsch med. Zeitung*, No. 77, has a reference to the case in which a

#### CROQUET BALL WAS RETAINED IN THE VAGINA FOR YEARS.

The patient was a country-woman, æt. 60, who complained of pain in the lower part of the abdomen and in the vagina, also of shortness of breath, cough, and a purulent vaginal discharge. She had been married 48 years, had borne two children, the first 34 years ago, and the second a year and a half later. The menses began at 20, and recurred at four weeks' interval, lasting five to seven days. After heavy work the patient felt the womb falling. She applied to a midwife, who, however, gave her no assistance, and in consequence of this she herself attempted to get relief by inserting various objects into the vagina. After the birth of the second child the womb fell further still, and she passed a croquet ball into the vagina. After that

she had no more symptoms of falling of the womb nor any pains, and the functions of both bowel and bladder were performed normally. On examining *per vaginam*, the introitus was found to be very much contracted, and behind the introitus the finger came upon a round, hard body. A muco-purulent discharge issued from the vagina. The urethra was of normal calibre, and clear urine was passed; neither was the rectum unduly pressed upon. The rounded foreign body was lying loose in the vagina, it could be grasped with forceps and moved freely. On account of the great narrowing of the vagina below, however, it was impossible to remove the ball entire; it had, therefore, to be broken up with a strong pair of forceps. The wood of the ball was unchanged; it was still fresh and firm. There was severe colpitis, and in places superficial ulcers were present. Patient discharged on the fifth day. The uterus was then small and atrophied, and in the vagina where the ball had been there was a ring-shaped contraction. There had been no perforation. There was no pain.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 23rd, 1904.

#### RECURRING ULCUS VENTRICULI PEPTICUM.

At the Prague meeting Schloffer showed a very interesting case of recurring ulceration of the stomach for which he had to perform gastro-enterostomy five times within two and a half years. The patient, æt. 33, had again developed the same condition of ulceration, and stenosis at the site of operation, which would again necessitate laparotomy.

#### TUBERCULIN REACTION.

Zupnik read an exhaustive paper to the members on the classification and reaction of bacteria. Commencing with their analogy to plant life he attempted to group them according to species and genera, into what he terms a natural system having well-defined marks of distinction. His whole system was established on morphology-colouring and pathological properties of the bacteria. As an example of these he selected Koch's acid-colouring species, which were known as the tuberculin bacilli. Their morphology was by true division with a Babes-Ernst body in the interior of the germ. A culture in clear bouillon gives a characteristic surface and its pathology produces tubercle. This family seem to give rise to different products; for example, he would quote twelve experiments on guinea-pigs with the different forms of Koch's species; six of them reacted with injections of Höchster's tuberculinum vetus as positive. This family appears to be closely connected with the harzstreptothrix, as tuberculin injections will react positively on lepra actinomycosis as well as tuberculosis, although in several experiments four different forms of streptothrix were found. From this and other experiments Zupnik concluded that the tuberculin reaction gave no diagnostic proof of this particular bacteria, although it defined the species.

The same reasoning was applied to typhus and paratyphus serum, which did not define the particular bacilli, but only the species of typhus bacilli, which might include the dysenteric, psittacosis, typhimurium and enteritidis, as well as the coli family. These again were subdivided by the agglutination phenomenon or the Gruber-Widal action, which could not be held as a specific etiological test. Again, these species of bacteria produce pathological changes which clinically and anatomically resemble each other, such as lepra

tuberculosis and Peru verruga, all resembling each other in having the tuberculous bacillus. He also recorded another clinical disease of the kidney which had its origin from Koch's bacillus, though apparently belonging to another tuberculous family which he would designate the smegma bacillus. In the discussion, Salus said that the family of tuberculous bacilli produced a chemical constituent which was not affected by the acid, and the same product could also be extracted from the bacillus itself. He believed there were different bacteria belonging to the same species producing similar metamorphoses and the same disease. He thought the experiments with the smegma bacillus did not prove the presence of tubercle owing to the absence of caseation, which did not exist, and which genuine tubercle always produced when inoculated. The tubercles alone were not characteristic, and required the caseation as proof. He admitted that different toxic substances could be extracted from the bacillus, many of which were specific, such as tuberculin, which had no characteristic phenomenon in the production of tuberculosis, and had no immunising power on animals. Zupnik replied that caseation in Koch's bacillus was neither characteristic nor proof of its genuineness as streptothrix and Pfeiffer's pseudo tuberculous bacilli all produced cheesy conditions in the tissues. As to the nephritic tuberculosis the diagnosis was the same in all bacteriological examinations, while the urine drawn from the ureter gave the same result, such as acid reaction, numerous leucocytes taking up acid colouring matter having genuine Koch's bacilli. In forty guinea-pigs which were inoculated with pure cultivated Koch's bacilli only the smegma bacilli were found.

#### FISTULA OF BLADDER AND BOWEL.

Kleinhaus showed a female, *æt.* 47, who had been confined sixteen times, and suffered from a fistula passing from the bladder into the bowel. The uterus and adnexa were normal, as well as the tissue around the cervix and fistula. He assumed that this condition was produced by an attack of perivaginitis phlegmonosa dessicans described by Marcomiet in 1865. This appears to have been induced by puerperal infection and injuries during delivery. It is possible to assume that infectious thrombi in the vessels of the vagina and portio were the starting point of the inflammations.

### The Operating Theatres.

#### NORTH-WEST LONDON HOSPITAL.

TWO CASES OF INTERMITTENT NASAL OBSTRUCTION WITH HYDRORRHOEA.—Mr. MAYO COLLIER operated on two cases of intermittent nasal occlusion with hydrorrhœa. The first case was that of a man, *æt.* 50, who had suffered for the last twenty-seven years from sudden, almost complete nasal occlusion associated with an outpouring of a large quantity of clear fluid. The attacks were so sudden that from a condition of complete and perfect nasal respiration the occlusion would suddenly come on, rendering the patient utterly miserable and quite unfit to continue his work for several hours to come. He stated that he had been examined and operated upon on several previous occasions with only slight temporary benefit. He had been advised to give up all alcohol and tobacco and undergo a course of medicine and dieting. This he had done religiously without apparently any benefit. Mr. Collier described the condition of the nose on admission. The whole mucous membrane was intensely red and

congested, there was much hypertrophic thickening of the lower turbinal body, culminating posteriorly in a left posterior hypertrophy, which almost completely occluded the posterior nasal opening. There was a fringe of thickening hanging from the middle turbinal body of almost polypoid consistence. On the right side there was a large ridge involving the right nasal cavity and touching the right lower turbinal body. Mr. Collier said two previous operations had been done in this case with the object of removing the posterior hypertrophy on the left side and reducing the lower turbinal body. These operations had resulted in considerable improvement, so much that the intermittent nasal obstruction on the left side had completely disappeared, and the discharge had been reduced considerably. He said he proposed now to remove the whole of the ridge on the right side so as to restore nasal respiration. The patient was anaesthetised with chloroform and placed in a semi-recumbent position on his left side. Mr. Collier made an incision along the lower aspect of the ridge with a scalpel, and introduced a fine Bosworth's saw. After considerable trouble (the ridge being very hard), the parts were sawn through and removed entire with forceps. Some subsequent chiselling had to be resorted to in order to complete the operation. Mr. Collier next demonstrated the complete freedom now obtained, by introducing a large piece of sponge on artery forceps, which now passed easily from front to back. There was considerable hæmorrhage during the operation, which, he said, would rapidly subside as the air passed backwards and forwards. No plugging or dressing was resorted to, but the patient was returned to bed. Mr. Collier said that in these cases no plugging was requisite, the air quickly arresting the bleeding and leaving a dry clot on the wounded surface.

The second case was that of a young man, *æt.* 24, who had suffered very much for several years from almost a similar condition as that seen in the previous case. The condition of the nasal cavities in the present case was one of marked lower turbinal hypertrophy with anterior and posterior enlargements. The attacks of sudden occlusion were so severe that the patient had been quite unable to follow his occupation from want of rest at night and generally impaired health. Mr. Collier said that in this case he had previously removed the two anterior hypertrophies and reduced the turbinal bodies on both sides with the galvano-cautery. He now proposed to remove the posterior hypertrophies with a cold snare. Twenty per cent. solution of cocaine with adrenal was placed on both hypertrophies, and, with the aid of good light, Jarvis's snare was introduced, first on one and then on the other side, and a structure as large as a cherry removed by slowly tightening the loop on the masses. There was no hæmorrhage, and the parts were apparently bloodless. Mr. Collier said it was quite unsafe to leave the wound without plugs or using the galvano-cautery; he preferred the latter, as the former would leave the patient in a miserable condition, and the plugs would probably have to be renewed in twenty-four hours. If the galvano-cautery were carefully applied and the exact site of the wound could be seen, there was, he considered, no danger of injuring the Eustachian tube or pharynx. Mr. Collier carefully marked on the galvano-cautery instrument the exact depth of the wound and seared the cut surfaces on both sides with

the cautery point. With this precaution, he remarked, there was no danger of subsequent hæmorrhage, and the patient would enjoy immediate benefit of restored nasal respiration and the advantage of the astringent and drying effects of the currents of air.

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## The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 26, 1904.

### ST. BARTHOLOMEW'S REBUILDING.

THE affairs of St. Bartholomew's Hospital appear to have drifted more or less into the position usually described tersely as "a deadlock." That fact may be pretty safely inferred from the reported resignation of the Treasurer, Sir Trevor Lawrence, and the Secretary, Mr. Cross. Both these gentlemen have been strongly committed to the policy which involved the extension of the present site of the ancient City institution, and of rebuilding thereon at enormous cost. That policy has from the outset been vigorously opposed by THE MEDICAL PRESS AND CIRCULAR, and we have no hesitation in saying that our objections have never yet been satisfactorily answered. The formal inquiry into the question of the advisability of retaining the City site, held by the body known as "The Lord Mayor's Committee," was not of such a nature as to inspire confidence. Neither the composition nor the methods of that body seemed to us worthy of adoption in investigating a matter of great public and, indeed, national importance. The suspicion that the final resolution was simply an expression of dogmatic and personal opinion, rather than the verdict of an impartial tribunal, was rendered inevitable by the refusal of the Lord Mayor's Committee to publish the evidence placed at its disposal. The transaction, indeed, savoured rather of the tactics of company promoting than of the publicity and candour that should be courted by every self-respecting medical charity. If the reasons for retaining St. Bartho-

mew's Hospital on its present site were cogent and overwhelming, as the Lord Mayor's Committee led us to believe, what possible objection could there be to letting the public know the why and the wherefore of their belief? To withhold such information was to suggest that the Committee had a weak case, that they were acting under powerful personal pressure, that they dared not state both sides of the question; in short, that they were registering in their report a private prejudice and opinion in place of a reasoned verdict. Our own objections to the scheme were clearly and repeatedly stated. Coming from a medical journal, they were entitled to a detailed public reply. There is no need to reproduce them here at length. Briefly stated, we objected to the enormous cost of the scheme as a larger modern hospital could have been erected for a far less sum in the suburbs; secondly, the day population of the City of London no longer demanded a vast residential hospital, nor was it desirable to treat patients in the vitiated atmosphere of a vast city area; thirdly, the abstraction of a million of money, the amount required for reconstruction, would infallibly damage other deserving medical charities; lastly, there being every likelihood that the greater part of medical education would, in the near future, be centralised, the erection of costly school buildings would be thereby rendered superfluous. Remonstrance proved of no avail; the public was asked to subscribe £500,000, and it was determined to rebuild the hospital on the present site. The upshot, after an interval of nine months, has been what some of the daily newspapers do not hesitate to describe as a "fiasco." It is stated that the total sum contributed has been £35,000 in place of the £500,000 asked for by the hospital authorities, or the million that the completion of the reconstruction scheme will require. Already the hospital has drawn £150,000 from capital to pay for the purchase of the ground from Christ's Hospital needed for the extension of site. Indeed, it looks as if St. Bartholomew's had been plunged into a financial morass, from which it will tax the resources of another committee to extricate its fortunes. The governors of the hospital are even applying, in their extremity, to King Edward's Hospital Fund for assistance. The full significance of that fact becomes evident only when we recall the fact that Sir Savile Crossley, the Secretary of the King's Fund, was a member of the Lord Mayor's Committee who opposed the reconstruction report in a minority of one, and who afterwards withdrew from that committee. Now that Sir Trevor Lawrence has resigned his post as Treasurer of St. Bartholomew's, it may be possible to reopen the question. In that case it would be advisable to appoint a representative committee or Commission of Inquiry chosen from men of recognised standing and judgment not connected with the City. The suppressed evidence of the Lord Mayor's Committee could then be produced and laid before the public. It is difficult to

conceive how any body of educated men in the present day could advocate a hole-and-corner treatment of a question of universal public interest. The welfare of St. Bartholomew's Hospital must concern every medical man as it does every citizen in the United Kingdom. Let us thrash the matter out on that understanding in the full light of day.

#### SCIENTIFIC PALMISTRY.

PALMISTRY, as expounded by self-styled "professors" of the art, has been considerably to the fore during the last few months in consequence of the prosecutions that have been instituted in different parts of the country, to test the validity of taking money for telling people a farrago of nonsense about themselves, their past, and their future. Happily, the law has been able to show that there are certain occasions on which it is not "a ass," and the prisoners have been pretty generally convicted. The offence in law that cheiromants commit is that of predicting the future; the mere practice of palmistry is not illegal so long as it confines itself to the delineation of character, though the puzzle will always remain why people wish to be told what they should know better than anybody else, namely, their own qualities and shortcomings. However that may be, the subject of palmistry and its influence over the human mind is not without interest to the anatomist and the psychologist, and the study of the hand has important medico-legal bearings that are well worth attention. Palmistry itself as practised by its ordinary exponents, even when rigidly confined to the portrayal of character, is beneath contempt, for the study devoted by them to the subject is so little profound that in many of their treatises the lines of the hand and fingers are not even correctly described. A mass of crude astrology is mixed up with incorrect anatomical detail, and the traditions of the sixteenth century are eagerly copied from one book to another; however, enough meretricious nonsense results to attract silly people to resort to the authors for advice. Piteable as this is, there is an idea abroad with regard to cheiromancy that there is "something in it," and it cannot be denied that, though scientific palmistry has yet to be developed, the hand is, or ought to be, a useful guide to a man's character and habits. The hand is admittedly the most complex and perfect piece of mechanism ever conceived, and especially in the development and specialisation of its outer half, and belongs more intimately and peculiarly to man than any single organ, except the brain. The relation between the brain and the hand was insisted on by Aristotle; Anaxagoras ascribed the superiority of man's wisdom to the possession of the hand; Galen thought that because man was the most sagacious animal, he was endowed with the possession of hands; and recently the leading medical philosopher of the day, Professor Clifford Allbutt, deplored the abandonment of the hands as an educational instrument by modern and mediæval

physicians. The hand, in fact, in virtue not only of its tactile sensibility, but also of its muscular sense, is one of the chief sense-organs of the body, and it is certainly the chief exponent of the will. Its shape, its development, the texture of its skin, and the fashion of its fingers are determined by occupation and habit, operating on hereditarily-acquired characteristics and predisposition. The whorls on the skin covering the terminal phalanges of the thumb and fingers are now known to be peculiar to the individual, and M. Bertillon has shown how valuable they are for purposes of identification. As an expression of the personal character and habit the hand is only second in rank to, if not actually equal with, the face, and though the significance of physiognomy has been carried to undue extremes by some of its adherents, no one attempts to deny the part played by the face in the portrayal of the character and the emotions. The physiognomy of the hand, if it may be so termed, has been little studied by scientific observers—a great pity, as their place has been filled by charlatans and humbugs, who have taken the opportunity to fill their own pockets by the proceeds of their quackery. The foundations for a true science of palmistry have been laid by such works as Sir Charles Bell's classic book on the hand, and Sir George Humphry's writings on the same subject, while Dr. Warner, in his "Physical Expression," has carried the matter further by describing and figuring various types of hands pertaining to certain dispositions. The topic is one of extreme interest, and as there appears to be a demand on the part of the public to know about their hands, it may be hoped that a means of providing them with authentic information on the subject may be forthcoming. The only way to prevent them from having recourse to "professors" who read the hands for a guinea, or "madames" who do the same for a shilling at church bazaars, is, provide them with a trustworthy substitute. Scientific palmistry may not have so many wonders to reveal as old-time cheiromancy, but it would at least tell the truth. Every observant physician is something of a physiognomist, it would not detract from his reputation if he were able to elicit all that the patient's hand could tell him.

#### Notes on Current Topics.

##### The Midwives Act.

It seems unlikely that the Midwives Act in its present form will ever become popular with the medical profession. One of its radical defects is experienced in the oft-repeated assertion that it calls into being an inferior kind of unqualified medical practitioner. Another vital flaw is the absence of any financial arrangement as to the payment of medical men when called in by midwives to attend "difficult cases." Now that the views of the medical profession have been set aside in favour of sentimental legislation, Government will have to provide a fair remuneration for its expert services. The Medical Guild o

Manchester, an alert and practical body, have lost little time in coming to a conclusion as to what constitutes a right and proper recognition of the kind. At their last quarterly meeting they adopted the following resolution:—"That when medical practitioners choose to attend confinements at the request of midwives, the minimum fee charged should be a guinea, to be paid at the time when possible. This should be carried out for the present as a tentative arrangement till fresh legislation dealing with medical fees has been brought forward." Bad as the principles involved in this Bill appear to us, its administration bids fair to become infinitely worse. Already the Board that controls its destinies has appointed unqualified women to inspect and control purely medical matters. We regret that any members of the medical profession should be so forgetful of their duty, and their dignity, as to sanction any arrangement of the kind. Dr. Ward Cousins, who has throughout offered a determined opposition to this and to other steps derogatory to the interests of the profession, deserves the thanks of all his medical brethren. We trust that no medical man in the United Kingdom will accept a less fee than one guinea when called in by a midwife.

#### Fright, or Fear-Illness.

THE influence of the mind in producing disease is a subject that has fascinated various pens, but one cannot say that much light has been thrown on the extraordinarily delicate relationship that exists between mental processes and bodily illness. Ladies in novels, after their love troubles have been sufficiently elaborated, have a convenient habit of succumbing to the affection known as a "broken heart," and children, in the same class of literature, run a terrible risk of developing that equally obscure malady, brain-fever, when the writer feels it necessary to gather up the sympathies of the reader for a final crushing exposure of the brutality of the parents. Romance-literature, however crude it may be, always reflects experience in some form or another, and novelists who tread on delicate pathological ground have a certain basis of fact which is none the less real because it is overloaded. Army surgeons can tell many a story with closed doors—which they would not venture on in speeches at military dinners—about the effects of fear on the constitution of the raw recruit—"funkitis" as it was christened during the Boer War. That fear can produce severe and perhaps even permanent change in the mental and physical organisation has been shown often enough, and an interesting illustration in point is recorded in Lady Thompson's account in the *Cornhill Magazine* of her experiences in Kastoria, whilst distributing the Macedonian Relief Fund. This province had been ravaged by the Turks the previous summer, and Lady Thompson says that there was an illness, more or less serious and sometimes even fatal, peculiar to Macedonia, openly confessed to by the sufferers and known by the

doctors as *strach* (fear). The victims were not only those whose houses have been burned and relations killed, but many who had spent weeks and months in suspense, hiding in out-of-the-way corners of the mountains. They were often unable to walk and to speak, or even to stand upright, and yet organically they were sound and uninjured. Women seem to have been more affected than men, but both sexes suffered. The condition would appear to have been one of profound hysteria, such as is met with under some forms of mental distress, but this does not help us much to its actual pathology. The sufferers were thoroughly overcome with severe mental prostration, and it is doubtful if they will ever be the same as they were previously.

#### Professional Penalty for Extortion.

IT is not often that a medical society is called on to reprove one of its members for demanding a high fee for professional services, yet this is what has recently occurred in Germany. A physician of good standing, being consulted by an American millionaire for appendicitis, advised operation, and recommended a surgeon. The operation was performed, and the physician then sent in a bill for four hundred pounds for his advice. The patient objected to the amount and tendered a smaller fee. The physician, however, insisted, and initiating legal proceedings, had the patient arrested and kept in custody. There is, of course, no ethical law by which the fees of medical men are controlled, and it is well recognised that a physician is justified in varying his fee according to the means of the patient. There is, however, a decent though variable limit to the demands of a man honourable in his profession, and we think that his *confères* acted rightly in dissociating themselves from the physician in question when he attempted by legal means to put a foreigner at disadvantage for the recovery of an obviously extortionate fee.

#### A Paradise of Bonesetters.

RAE, the Scotch miner-bonesetter, is not to have things all his own way up at Blantyre. The railway trains still disgorge the lame, the halt, and the impotent in considerable crowds, attracted by the extravagant claims of his wonderful "system." Indeed, it is reported that cripples are coming from Germany, Sweden, Denmark, South Africa, and America to subject themselves to his manipulations, and altogether he seems to be having—as the schoolboys say—"a good time of it." But on the principle that competition is good for trade, two other "specialists" have set up in the neighbourhood so that they may enjoy the crumbs that fall from Rae's operating table. One of these individuals, Thomas Gilchrist by name, has indeed "gone one better" by announcing that he takes sciatica into his therapeutical province, and as Rae does not seem to be much of a hand at sciatica, patients having that trouble go on to Gilchrist. But dwellers south of the Tweed, to whom the pre-eminence of country is dear, will be

glad to hear that Scotland is not to go unchallenged for its supremacy in bonesetting, for another performer, an Englishman, named Fred Barker, is hastening to the scene, and is about to start in business midway between Rae at Blantyre and Gilchrist at Wishaw. Mr. Barker one would judge to be something of a capitalist, as he offers to pay £500 to any philanthropic institution if his system of manipulative surgery is not pronounced superior to, and productive of more benefit than, the scalpel of the local doctors. If, on the other hand, he comes off victor in the contest he is prepared to give £250 to found a school of bloodless surgery in Lanarkshire. With so many provincial universities coming into being, this new one (if founded) may make things uncomfortable, but we fear its handsome endowment will hardly succeed in retaining a professor unless he be also allowed the privilege of private practice in his wonderful arts. Altogether things seem very merry up in Lanarkshire, and Carlyle's quoted estimate of the British population does not seem likely to be falsified thereby in the near future.

#### The National Epileptic Colony.

ON Thursday last, October 20th, the Epileptic Colony at Chalfont St. Peter, in Buckinghamshire, conducted by the National Society for the Employment of Epileptics, marked an important stage in its rapid evolution by the opening of an excellently arranged and well-equipped administrative building, which, like so much in connection with the Colony, has been made possible by the judicious munificence of Mr. Passmore Edwards. The opening ceremony clearly indicated the keen interest taken by both profession and public in the rational and hygienic care of the epileptic. Lord and Lady Rothschild attended, and Sir William Broadbent and Dr. Buzzard took part in the proceedings, and Dr. Fletcher Beach, Dr. Shuttleworth, Dr. Aldren Turner, Dr. Kelynack, and others were present. Much praise is due to Mr. Nicholls, the chairman, for his wise pioneership in the development of the Colony. The new house contains offices, rooms for the staff, and a thoroughly modern and up-to-date kitchen. The various buildings which constitute the Colony are excellent for their purpose, and the whole conduct of the place appears to be characterised by scientific precision and sound common sense. There is much ground which allows of a free and open-air life and useful outdoor employment. This new but now large and flourishing Colony should be well known to medical men, who are so frequently called upon to advise regarding the protection and upbringing of epileptics.

#### The New President of the Royal College of Physicians, Ireland.

DR. W. J. SMYLY, who was elected President of the Royal College of Physicians of Ireland at its last meeting, is, as is well known, one of the most prominent of British gynaecologists. Dr. Smyly entered the medical profession through the portals of Dublin University in 1872. In 1877,

he became a Fellow of the Royal College of Surgeons, a distinction which he subsequently relinquished in order to take the Fellowship of the College of Physicians. In 1882, he was appointed gynaecologist to the City of Dublin Hospital, in succession to Dr. Arthur Macan, who has been elected to the vacant Mastership of the Rotunda Hospital. In the latter post, Dr. Smyly again succeeded Dr. Macan, and during the next seven years laid the foundation of his wide reputation. During his Mastership, the new gynaecological wing of the hospital was built, and many important reforms were introduced, notably nursing by trained nurses under a trained lady superintendent. So successful were these reforms that in the last year of his Mastership the mortality rate in the maternity department was reduced to the lowest that had ever been known in the hospital—only one death occurring amongst the 1,524 patients that were confined. On leaving the hospital, Dr. Smyly was appointed gynaecologist to the Adelaide Hospital, a post which he still holds. Amongst his other distinctions may be mentioned the Presidency of the British Gynaecological Associations and of the Obstetrical Section of the Royal Academy of Medicine in Ireland.

#### Venous Thrombosis in Typhoid Fever.

THE toxins elaborated by the *Bacillus typhosus* within the body are so insidious in their action, and so far-reaching in their effects, that no system can be said to be exempt from one or other complication or sequela. Modern pathological research has shown that the vascular system bears much of the brunt of the poison of typhoid fever, especially in the later stages of the disease. It has recently been found that evidences of functional and even organic disease of the heart may be traced to an antecedent attack of enteric fever, while arterio-sclerotic changes within the vessels have also been pointed out as a not infrequent sequel of this affection. That venous thrombosis is another complication likely to occur in the course of typhoid fever, or during convalescence therefrom, is shown by an analysis of forty-two cases of this condition made by Professor W. S. Thayer, (a) of Baltimore. Of these the left side was affected in twenty-six cases, while the femoral vein was thrombosed in twenty-one instances. The condition generally makes its appearance about the third week of the disease, but in some cases it may be considerably delayed. The onset is usually associated with sudden pain in the affected part, chills and fever. Some swelling of the thrombosed vein nearly always occurs, and there may be oedema of the adjacent integument. If the blood be examined at this period a leucocytosis will be found coincidently with the appearance of the thrombosis. In one fatal case the *B. typhosus* was obtained in pure culture from the thrombus. The after-results of venous thrombosis are important, as in almost all

(a) *Med. News*, October 1st, 1904.



the cases more or less permanent disability of the affected limb follows. Such symptoms as cramps, stiffness, and swelling of all the tissues of the leg were found several years after the attack. The risk of embolism is one which must, of course, be specially guarded against.

#### Baron Dimsdale.

BARON DIMSDALE, whose miniature-portrait has been so wantonly stolen from the National Portrait Gallery, lives in history as the medical man who received the largest fee for any single service. Born of Quaker parents in Essex, in the year 1712, and educated at St. Thomas's Hospital, he rapidly rose to fame as a physician, and became a Fellow of the Royal Society. It was in connection with inoculation for small-pox that he chiefly attained celebrity. This practice had been introduced into England by Lady Mary Montagu and others in the early part of the eighteenth century, and was widely practised till about 1740, when in consequence of many fatalities occurring among the inoculated, it fell into disfavour. Sutton, however, in 1763, announced a method by which he could assure that the resulting attack of small-pox should be mild, and he speedily gathered a large practice. Dimsdale modified the Suttonian method, and in his turn gained a wide connection, but though the matter had been frequently discussed, the so-called secret on which Sutton and Dimsdale built up their success has never been accurately determined. Dimsdale's peculiar luck came in his being summoned, in 1768, to Russia to inoculate the Empress Catherine and her son, the Grand Duke. Fortunately for him the operations were both successful, and he was rewarded with a fee of £10,000, an allowance of £2,000 for travelling expenses, an annuity of £500, and, as though pecuniary reward was not sufficient, was created Baron of the Russian Empire, Councillor of State, and Body Physician to the Empress. He returned to England, and soon afterwards was elected M.P. for Hertford, in which town he practised the combined callings of banker and physician. In 1781 Dimsdale was sent for to Russia again. This time he inoculated the Grand Duke, who was afterwards the Emperor Alexander, and the Duke's brother Constantine; his services were again rewarded with handsome fees and further titles. Dimsdale lived for nearly twenty years to enjoy his honours and emoluments, and dying at the ripe age of eighty-eight, was buried at Bishop's Stortford in the Quaker's burial-ground. Baron Dimsdale may not have been one of the greatest physicians, but he was certainly one of the best rewarded.

#### Cyto-Diagnosis in Nervous Diseases.

WITHIN the last few years attention has been drawn to the help that may accrue to diagnosis from the study of the cells contained in the fluids of the body. There is no doubt that, for instance, the cellular elements of a pleural effusion vary to a considerable extent with the

cause at work. This is, however, the simplest case that occurs, and we think that there has been, in some quarters, a tendency to expect equally speedy results from an examination of the fluids of other serous cavities. Some writers, for instance, have recorded rosy accounts of the great assistance given to the diagnosis of nervous diseases by the examination of the cells in the cerebro-spinal fluid. It has been held that an increase in the number of lymphocytes in that fluid is pathognomonic of meningeal irritation, and that it particularly occurs in the early stages of general paralysis of the insane and tabes dorsalis—the so-called parasyphilitic conditions. Fuller investigation, however, shows that these conclusions are somewhat hasty. Far from lymphocytosis of the cerebro-spinal fluid being confined to parasyphilitic cases, it has been found in such varying inflammations as herpes zoster, sciatica and parotitis, and in such intoxications as are due to tetanus, uræmia, and syphilis. At present one can hardly go further than the statement that while lymphocytosis is usually associated with tabes and general paresis, it is by no means to be relied on as diagnostic. It is, at best, but one point to be taken into consideration in basing a diagnosis on general grounds.

#### Frost-Bite in Tibet.

FROM a medical point of view perhaps the greatest hardship undergone by our troops in the Tibet Expedition was the exposure to great cold. Although in all campaigns soldiers are accustomed to suffer from both cold and exposure, yet a British army is rarely subjected to the Arctic cold encountered in the passage of the Himalayas. Lieutenant Davys, I.M.S., one of the medical officers attached to the expedition, has placed his observations on record, (a) and has given, in particular, an interesting study of frost-bite. Very rarely does cold, of itself, produce local necrosis, though this may occur if the cold is both severe and long continued. Much more commonly necrosis occurs as the result of carelessly applied heat. In Manitoba, where frost-bite is common, serious results rarely follow except in the case of new arrivals in the country, who, in their ignorance, immediately apply heat to the affected part. Similarly, among our troops in Tibet, the soldiers, entirely unused to the condition, as Dr. Davys notes, "used to hold the frost-bitten part practically in the fire." When this is done, a violent rapid œdema takes place, causing pressure on the already damaged tissue, followed by moist gangrene. As treatment, in mild cases rubbing is of itself effectual, but in more severe cases other steps must be taken to raise the temperature very gradually. The usual method is to immerse the part in a vessel of ice-cold water, whose temperature is then slowly raised by its being placed over a fire, friction being kept up throughout. In the most severe cases, where necrosis has

(a) *Indian Med. Gaz.*, July, 1904.

actually taken place, Dr. Davys found operative measures invariably necessary.

### A New Cancer Treatment.

DR. DOYEN, of Paris, informs us that he has not found the specific treatment for cancer any more than he has discovered the cancer microbe. He has discovered in the neoplastic tissues a micro-organism which he has named micrococcus neoformans, of which the cultures, weakened by certain processes and additions of quinine or of arsenic, form the basis of his anti-cancerous serum. At the French Surgical Congress, held last week, he gave the technical details of the manufacture of his antineoplastic liquids, and insisted upon the fact that the production of toxins obtained by the cultures of micrococcus neoformans was delicate, and so slow that two or three years elapsed before it was ready to be utilised therapeutically. Doyen brought forward statistics of 242 cases of cancer of all sorts treated by his method. The following are the results:—Forty-two apparently absolute cures, some of them now of four years standing. In 128 cases the treatment has given no result because it was commenced too late or interrupted too soon. Six patients died accidentally who were cured of their cancer, and the cases of twenty others have not been followed up. The following conditions are suitable for serum treatment, namely, all cases of malignant tumours which are doomed to relapse after operation; all confirmed cancers in which total removal cannot be practised; all tumours inoperable from the fact of their size or because important organs are involved. Dr. Doyen has kindly sent us a report of his address published in the *Bulletin Medical*, and from it we learn that he has considered the possibility of an anti-cancer vaccination giving immunity for a considerable period to susceptible persons.

### Chronic X-ray Dermatitis.

CERTAIN daily newspapers have raised the ghost of a well-known malady—as is their wont—and have done their best to make the blood of the public turn to water with their turnip-headed wonder. The fact that workers with the Röntgen rays are subject to an extremely chronic, distressing and incurable inflammation of the hands has at length penetrated the recesses of Fleet Street. The further fact that several cases of cancer have developed in connection with chronic X-ray injury seems to have inexpressibly inflamed the editorial imagination; the yellow press of the kingdom has been accordingly flooded with startling headlines, pictures, interviews and startling columns horrid with fact and fancy. Among the interviews we regret to see one with a Midland worker in the X-rays, who has apparently so far forgotten the unwritten rules of the medical profession as to furnish his experiences to a reporter, to be published under his own name. The views of a London specialist have been quoted copiously in

relation to a book, for which notice he is obviously not answerable. As a matter of fact the chronic dermatitis of Röntgen-ray workers has been known for a long time, and was described fully some six or seven years ago in the book which is the standard English authority on the Röntgen rays in medical work.

### Imperial Sanitary Commissioner for India.

THE scheme of sanitary administration for India that was recommended by the Plague Commission has been some years in meeting with recognition at the hands of the responsible Government, but with plague still rife in the country the staff of the medical department seems to have been too busy to attend to other duties than the immediate occasion required. The Government have at last determined to start putting the scheme into operation, and their first step has been the appointment of an Imperial Sanitary Commissioner for the whole Empire, whose duties will be entirely severed from those of the Director-General of the Medical Service. This is certainly a step in the right direction and the salary fixed for the new post, Rs. 2,000 to Rs. 2,500 a month, is, on the principle that people value a man's advice at what they pay him for it, an earnest that his recommendations will be regarded seriously. A somewhat refreshing feature, too, is the fact that a comparatively junior officer, Major Leslie, has been appointed to the position, which looks as though the Government wished to begin with an open mind, free from tradition and bias. The Sanitary Commissioner will advise the Local Government as to the principles on which their health organisation should be moulded, and how it should work, as he will have under his charge the very important department dealing with the institutes and laboratories for carrying on research-work and the manufacture of curative and minimising sera in India. To the Imperial Government he will act as sole adviser on all sanitary questions, and his recommendations will not have to pass through the office of the Director-General. It seems rather curious that the creation of an office which is practically that of a Minister of Public Health should be recognised as necessary and salutary in one of our dependencies, whilst in the Mother Country any proposal to create a similar post is hardly regarded seriously.

### PERSONAL.

DR. LIONEL H. WEATHERLY will preside at the annual dinner of the Bristol Medical School, to be held on October 28th, on which occasion Sir William Church will be the guest of the evening, and earlier in the day will distribute the prizes on behalf of the Faculty of Medicine of the University College, Bristol.

THE Sanatorium at Quarrier's Homes, Bridge-of-Weir, recently acquired by the Paisley Association for the Prevention of Consumption, was formally opened on the 15th inst., by Sir Thomas Glen-Coats, Bart., of Ferguslie Park, Paisley.

DR. ANDREW GRAHAM, of Currie, on the occasion of his semi-jubilee of practice in the district, was

entertained last week at a complimentary dinner in the Gibson Craig Memorial Hall, Currie.

THE new crematorium of the City of London Cemetery, Little Ilford, Essex, was opened by William Joseph Downes, Esq., Chairman of the Sanitary Committee, acting as the Burial Board of the City of London, Tuesday (yesterday).

IT is the intention of his friends in Belfast to entertain Professor Lorrain Smith at a public dinner before his departure from Queen's College to take up his duties at the Victoria University. The dinner will probably take place on November 3rd.

WE are officially informed that the Secretary of State for War has approved of the re-appointment for a further period of three years of the present civilian members of the Advisory Board for Army Medical Services:—Sir C. B. Ball, M.Ch., Dr. J. Galloway, Sir E. Cooper Perry, M.D., Sir F. Treves, Bart., K.C.V.O., C.B.

IT is announced that Sir Trevor Lawrence, the treasurer of St. Bartholomew's Hospital, and Mr. W. H. Cross, the clerk of the institution, have handed in their resignations, with intimation that they are willing to carry on the work until suitable successors have been found.

ON the 18th inst., Sir Frederick Treves opened a new hospital at Crewkerne, erected at a cost of £5,000.

DR. AMELIA WILKES LINES, who recently celebrated her eightieth birthday, is the oldest practising woman doctor in the world. She was the first woman to receive a diploma in the State of New York, and has practised in America since 1854.

DR. BYROM BRAMWELL will preside at the dinner of the Edinburgh University Club at the Criterion Restaurant, on Wednesday, November 9th, 1904. Tickets may be obtained from the Honorary Secretaries, James Taylor, 49 Welbeck Street, London, W., and G. A. Sutherland, 73 Wimpole Street, W.

MR. J. HALSEY MORTON has been appointed assistant secretary to the Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead, and Northwood, Middlesex.

THE Fitzpatrick Lectures before the Royal College of Physicians of London will be delivered by Dr. J. F. Payne, whose first lecture will deal with "English Medicine in the Anglo-Norman Period and Gilbertus Anglicus," while the second lecture will discuss "Ricardus Anglicus and the Teaching of Anatomy in the Middle Ages."

THE Bradshaw Lecture before the same College will be given by Dr. F. Foord Caiger on November 15th, on "The Treatment of Enteric Fever."

THE Horace Dobell Lecture of the London Physicians will be delivered by Dr. E. Klein, F.R.S., on November 22nd, the subject being "The Life-History of Saprophytic and Parasitic Bacteria and their Mutual Relation."

At the Royal College of Surgeons of England the Bradshaw Lecture will be given on December 1st by Mr. A.W. Mayo Robson, vice-president, on "Cancer and its Treatment"; and the Hunterian Oration by the president, Mr. John Tweedy, on February 14th, 1905.

At a meeting of the Aberdeen University Unionist Association on October 14th, the executive, after full consideration of the circumstances, again heartily and

unanimously approved of the prospective candidature of Sir Henry Craik, K.C.B., LL.D., and at the same time disavowed any connection with another Association recently formed under a similar title to their own.

LORD BALFOUR OF BURLEIGH, Chancellor of the University of St. Andrews, on Monday, October 17th, formally opened the new buildings which have been erected at a cost of £20,000 for the accommodation of the Medical School of University College, Dundee, which is now an integral part of that ancient University.

OF the total cost of the new St. Andrews buildings the University Court provided £14,000, and Sir William Gilvly Dalgleish gave a donation of £5,000.

THE annual dinner of the past and present students of the National Dental Hospital will be held at the Trocadero Restaurant on Saturday, November 19th, when the chair will be taken by Mr. Andrew Clark, D.Sc., F.R.C.S.

DR. WILLIAM COX, of Winchcombe, Gloucestershire, who has given his services to the parish church as honorary choirmaster and organist for thirty-two years, has recently been presented with a life-size portrait of himself, together with a tea service and salver in massive silver.

THE London companies of the Royal Army Medical Corps (Volunteers) will attend divine service at St. Bartholomew the Great on October 30th, when a sermon will be preached by the Rev. Sir Borradaile Savory, Bart., Rector of the church and Acting Chaplain of the companies.

WE are informed that the Awards Committee of the St. Louis Exhibition has conferred upon the Wellcome Chemical Research Laboratories a grand prize and three gold medals, in recognition of the importance and educational value of the chemical and pharmacognostical researches conducted under the direction of Dr. Frederick B. Power.

LIEUTENANT-COLONEL WILLIAMSON, R.A.M.C., at present on the Aldershot Medical Staff, has been appointed Administrative Medical Officer in India.

THE Paris *Matin* announces the death of Dr. Tillaux, Professor of Surgery, President of the Academy of Medicine, and Grand Officer of the Legion of Honour.

DR. ARTHUR NEWSOME (Medical Officer of Health for Brighton) last week delivered an address at the inaugural meeting of the York Medical Society, selecting as his subject "Social Evolution and Public Health."

## Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

### SCOTLAND.

#### NEW MEDICAL SCHOOL AT DUNDEE.

LORD BALFOUR OF BURLEIGH, Chancellor of the University of St. Andrews, opened the new buildings at University College, Dundee, on the 17th inst. Hitherto the development of medical teaching at Dundee has been greatly hampered by the inadequacy of the premises in which it has been carried on, but the new accommodation provided will, it is hoped, meet all demands for many years to come. Little attention has been paid to architectural adornment, the main object having been to secure internal efficiency and convenience. The lecture-rooms have accommodation for a total of 500 students, and there is a specially fine dissecting-room equipped with all the most modern appliances for the teaching of anatomy. Lord Balfour, in performing the opening ceremony, said that the day marked the completion of the first step which was in view—namely, the establishment of a great medical

school in Dundee—when the union between St. Andrews University and University College, Dundee, was first proposed. Though unforeseen difficulties had arisen, the union was finally accomplished in 1897, at which date Dundee had chairs which provided for the education of students during the first two years of their course. After the union new chairs were added, and now a complete medical curriculum could be gone through in Dundee. The new premises had cost only a little in excess of the estimated £20,000; they would accommodate classes for anatomy, physiology, pathology, materia medica, surgery, obstetrics, medical jurisprudence, &c., with museums, laboratories and classrooms for various subordinate subjects. While congratulating all those concerned on the rapid progress which had been made during the two years which had passed since Mr. Carnegie laid the foundation-stone, Lord Balfour said that they must not yet think they were in such a position that they could afford to "rest and be thankful." Other important developments were to be inaugurated, even during the present session. Property had been acquired which was about to be converted into a University library and a students' union. A munificent benefactor, Mr. Fleming, of London, had given a large sum for a gymnasium and fives court. The speaker concluded by hoping that the new medical school would fulfil all the bright future foretold for it. Speeches were also made by Principal Donaldson, the Earl of Camperdown, and Principal Yule Mackay, and the proceedings terminated by a luncheon at which about one hundred gentlemen were present.

**ST. ANDREWS UNIVERSITY RECTORSHIP.**—At a recent meeting of the students there was a practically unanimous opinion expressed in favour of electing Mr. Andrew Carnegie for a second term of office as Lord Rector. The name of Mr. Andrew Lang was also proposed; he has many warm friends among the students, but the measure of support given him at the meeting was not such as, meantime at least, would warrant his nomination.

**PROPOSED AGE LIMIT AT THE ROYAL INFIRMARY, EDINBURGH.**—It is understood that the Joint Committee of the managers and contributors to the Royal Infirmary appointed in the early part of the year to consider the question have drawn up a report recommending that it be left entirely to the managers to grant or refuse applications from members of the staff for an extension of five years in their appointments. The original proposal was that the physicians and surgeons should retire at sixty-five, and objection was then taken to the exclusion of the University professors from the operation of the rule. Apparently the Committee have simply reported in favour of the *status quo*—a minority of two favoured the adoption of the age limit.

**OPENING OF THE SESSION AT EDINBURGH UNIVERSITY.**—The medical classes were opened for the winter on the 18th, for the most part without any formal introductory lectures, the professors at once beginning the year's work. Professor Chiene, however, commenced his lectures on surgery by an address on the responsibility of surgeons, and Professor Simpson devoted the first lecture of the course on obstetrics to a historical sketch of the teaching of midwifery in the eighteenth century, in which he showed that the Edinburgh chair was the oldest in Europe, its date anticipating that of the Florentine Chair of Midwifery (1728) by two years.

**QUEEN ALEXANDRA SANATORIUM AT DAVOS.**—Lord Balfour addressed a meeting in Edinburgh in favour of this object on October 18th, the outcome being, in addition to the intimation of several substantial donations, the formation of a Committee to secure help for the scheme in the Edinburgh district. Since the Glasgow meeting was held about a week ago the Lord Provost of Glasgow has received nearly £200 for the same object.

A SUM of nearly £15,000 has now been received on behalf of the present year's collection for the Hospital Saturday Fund, the result mainly of weekly or other periodical contributions in the workshops, &c., of London.

## 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,—While thanking you for your kind reference to myself in the editorial columns, respecting my paper, "On the Treatment of Inoperable Cancer by Hypodermic Medication," published in your last issue, I would like to make it plain that I do not claim to be the originator of this method of treatment, but only to draw attention to the use of chian turpentine, and to the use of the soap solution of Mr. J. H. Webb, of Melbourne, in this connection.

I am, Sir, yours truly,

JOHN A. SHAW-MACKENZIE.

42 Green Street, Park Lane, W.,  
October 20th, 1904.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*  
SIR,—In your "Notes on Current Topics" of last week, you say that "Dr. Shaw-Mackenzie has made the pioneer move in the necessary experimentation," *i.e.*, in cancer. Though I consider this an exceedingly small matter, as experiments with hypodermic injections in the treatment of cancer are neither original to Dr. Mackenzie nor to myself, yet for the sake of accuracy I would like to say that I suggested to Dr. Mackenzie that he should try hypodermic injections in cancer, and told him what I was then using in that way.

I am, Sir, yours truly,

GEORGE E. KEITH.

7 Manchester Square, W., Oct. 21st, 1904.

[The modification of the above-quoted statement had already reached us from Dr. Shaw-Mackenzie himself. Our reference was rather to the particular *technique* than to the principle.—ED.]

### A DISCLAIMER.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*  
SIR,—I have seen an article in your paper, entitled "Eye Massage," in which occurs the following sentence:—"Under the leadership of Mr. Stephen Coleridge, they (the anti-vivisectionists) have practically declared war to the knife with the medical profession."

I desire to say that I have never in my life attacked the medical profession, and I shall therefore feel obliged if you will be so good as to produce any utterance of mine that you think affords you any justification for this statement of yours.

I have been told that there are some thirty or forty thousand members of the medical profession, and I know there are but 350 licensed vivisectionists in this country, and not even all of these hold medical degrees.

You might with as much justice accuse a man of attacking the art and profession of music because he objects to hurdy-gurdies.

As to Mr. Stephen Smith and eye massage, as the National Anti-Vivisection Society which I represent and I myself individually have never had any connection of any kind with the Anti-Vivisection Hospital, I fail to see why my name should be introduced into your article on the subject.

I am, Sir, yours truly,

STEPHEN COLERIDGE.

92 Victoria Street, London, S.W.,  
Oct. 18th, 1904.

[We insert the above letter with pleasure, as we should be sorry to treat an opponent in any way open to a suspicion of unfairness. We do not, of course, hold the Hon. Stephen Coleridge responsible for all the acts of anti-vivisectionists generally, nor did we state that he or the National Anti-vivisection Society were particularly concerned in the establishment of the Anti-vivisection Hospital. He will, however, excuse us for designating him as leader

of the anti-division movement, although many anti-divisionists do not follow his banner, for since Miss Cobbe's retirement he has, by his energy and championship, come to be regarded as the protagonist of the cause. As Mr. Coleridge has lost few opportunities of attacking hospitals with medical schools attached to them—institutions which are representative of all that is best in the thought and feeling of the medical profession—besides many medical men from Lord Lister downwards, he can hardly complain that he is misrepresented when we say he "practically" wages war against the medical profession. A man who continually attacks hurdy-gurdies may, not improperly, be said to be waging war with the organ-grinding profession. The principle of trying to divert public subscriptions from hospitals in which any member of the staff has ever performed an experiment on a lower animal is one against which we protest, and as late as September 20th of this year Mr. Stephen Coleridge attempted to influence such a diversion of funds by letters to the *Daily News* and *Morning Leader*. The gross statistical fallacy by which Mr. Coleridge arrived at the results he put forward in that letter were exposed by Mr. Downton at the time.—ED.]

#### THE MIDWIVES ACT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The Midwives Act, as you are aware, has very seriously altered the position of the medical man with regard to the practice of midwifery, the greater part of which will probably in the future be done by registered midwives. The Act compels the midwife, under certain scheduled conditions, to demand the assistance of a medical man, and to state in writing the nature of the necessity. The Act does not, however, make any arrangement for the payment of the doctor's fees, nor is it compulsory on the doctor to obey the midwife's summons.

The Medical Guild has fully considered the question, and at the last quarterly meeting the following resolution was adopted:—"That when medical practitioners choose to attend confinements at the request of midwives the minimum fee charged should be a guinea, to be paid at the time when possible. This should be carried out for the present as a tentative arrangement till fresh legislation, dealing with medical fees, has been brought forward."

The whole question is, of course, in a transitory stage, and it is important not to do anything against the interests of the profession by ill-considered individual action, especially by cutting down the minimum fee.

We are, Sir, yours truly,

D. OWEN,

J. H. TAYLOR,

Hon. Secs. of The Medical Guild.

Manchester, October, 1904.

[We entirely approve of the attitude adopted by the Medical Guild with regard to this important matter, and desire to urge strongly on medical men the necessity for united action. If a firm stand is made now, the public will be compelled to recognise the rights of the medical profession. Otherwise, an attempt will be made to establish a custom of medical attendance in these cases at a ridiculous fee.—ED.]

#### PROPOSED STERILISATION OF CERTAIN DEGENERATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of October 19th, you refer to the above grave question under the somewhat sensational heading, "A Short Way With Lunatics." Now such a heading is hardly in keeping with that fair style we are—thank Heaven!—accustomed to meet with in THE MEDICAL PRESS AND CIRCULAR. If I adopt your description—"A Short Way With Lunatics"—it would, to me at least, mean that lunatics are to be killed. Had you said, "A Short Way With Lunacy," no one could honestly object.

I am more than pleased to see that Dr. F. J. Smith—

recognising that lunacy and other forms of degeneracy are so greatly on the increase and that there is no real cure—has followed me in adopting my suggestion of sterilisation of special degenerates. I would, however, differ just a little from him. He advises that a woman with puerperal mania who has murdered her child should undergo oöphorectomy. I would not wait in such case for the murder of her child. If she developed insanity during pregnancy, the puerperium, or suckling, I would advise that she be forthwith sterilised, and I question if it would not be a good thing for our race if abortion were brought on if she developed insanity a few months after conception. Dr. Smith's plan of waiting until the child is murdered is, perhaps, good, in so far as it would prevent the poor degenerate child from living under a mental curse handed down from its parent, or even becoming ultimately a mother. I would, however, suggest that the child be sterilised. Please note, I do not for an instant suggest that Dr. Smith advocates the killing of the child by its insane mother. I have come in contact with so much cackling and garrulous accusations of having advocated suicide by the insane, when I published my book upon the above proposal, that I am now willing to labour a point with words, so that the meanest intellects—if honest—can understand.

I am, Sir, yours truly,

ROBERT R. RENTOUL.

Liverpool, October 22nd, 1904.

#### ALCOHOL AND INSANITY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As a temperance reformer, let me first thank you for the attention and able treatment which the question of the abuse of alcohol constantly receives in your paper. The lecture by Dr. Clouston, published in THE MEDICAL PRESS AND CIRCULAR of October 12th, furnishes most powerful arguments to the cause of temperance, and the value of these arguments would not be much discounted if the suggestion made by Dr. Walsh to-day (October 19th) were to turn out correct. Whether in some instances incipient insanity develops dipsomania, or in other cases alcoholism produces insanity, it is equally evident that much good would be done if drinking could be diminished, or, at least, if no alcoholic drink should be procurable save such as is of the purest and least toxic manufacture. The harm done by beer is infinitesimal compared to that brought about by the raw spirits which the majority of drunkards—the poorer classes—consume. It is spirit-drinking which carries most to ruin, and the ruin is more quickly and certainly brought about owing to the fact that the spirit is crude, unrefined, and loaded with fusel oil and other kinds of impurity. I am not a believer in the power of laws to do away with drunkenness, but I think the Legislature might well attempt to prevent the sale of all alcoholic drinks which by their preventable impurity act as powerful poisons upon the pitiable victims of drink craving.

I am, Sir, yours truly,

A TEMPERANCE REFORMER.

October 19th, 1904.

#### PUBLIC SCHOOLS AND FLOGGING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Why is it that, in almost every controversy on the flogging question, some public school man comes forward to assure the public that he, even he, was himself flogged in his boyhood? Does he do so from a philanthropic desire to supply an element of comedy to a somewhat dry discussion? Or does he imagine that his own early birchings are, in some mysterious way, really relevant to the point at issue? Thus, in the recent inquiry into the birching scandal at the Sparkhill Police Court, Birmingham, the Chairman, Mr. R. H. Amphlett, K.C., is reported to have observed that "he knew the birch very well when he was at Eton." I can quite believe it; but what possible bearing has it on an inquiry into the conduct of a superintendent of police who birched a boy illegally? Can it be that these gentlemen who obtrude their

private experiences in a public discussion intend us to understand that, in view of the superlative excellence to which they have now attained, any punishment which they underwent in youth must of necessity be good for other people, whether in itself legal or illegal? If that be their meaning, the reasoning does not seem very cogent; indeed, their lack of logic raises sad suspicions that they were birched in vain. We prefer to think that they merely wish to enliven the proceedings by a jocose, though irrelevant remark. Perhaps Mr. Amphlett will enlighten us?

I am, Sir, yours truly,

PUZZLED.

October, 1904.

[The use of the birch generally is a subject on which the views of the medical profession could hardly fail to be most interesting and valuable.—ED.]

#### "PUBLIC OPINION" AND THE HOSPITAL PENNY FUND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Owing to the fact that the above fund has been severely attacked by the *Hospital* and various other newspapers, we should be glad if you will make the following fact known through the medium of your journal. The principal of these attacks has been that 25 per cent. of the total received for the hospital stamps goes into the promoter's pockets. This is not the case; the whole of the prizes and expenses in the administration of the fund is paid out of the 25 per cent. in question, and this absorbs that amount, which has been arrived at after very careful consideration.

Mr. George Herring, who has been concerned in almost every class of scheme for obtaining money for the hospitals, writes us as follows:—

DEAR SIR,—I think your opponents have treated the scheme unfairly. If they objected on the score of its being immoral to give prizes in the cause of charity, it is a point which each person must judge for himself; but if on the score of the deduction of 25 per cent., I confess candidly that at bazaars and other society methods of collecting money for charities, upwards of 50 per cent. is frequently deducted for expenses. I fail to see the objection to your deducting the 25 per cent. Then, as I understand, you propose to deposit or properly guarantee the £5,000 prizes, therefore the hospitals must benefit to the extent of £15,000 before you are recouped. It is, therefore, you that run the risk, and in my mind a great risk, as you are opening up fresh ground which can only be worked by an army of energetic workers, who expect money prizes, and do not work for charity only, but for themselves. Hence, I see no objection to the 25 per cent. Having written you my views I yet counsel you not to force the scheme, if the hospitals are not in favour of it, as I think the public will not take your side against the general verdict.—Yours truly,

(Signed) GEORGE HERRING.

1 Hamilton Place, Piccadilly, W.

October 13th, 1904.

Upon this letter we had lengthy interviews with Mr. Herring, who is thoroughly interested in the scheme, and considers it should be accepted in a universal way. Mr. Herring is further strictly in accord with our views on the suggestion made by the *Hospital* in the last week's issue of that journal, in calling a meeting of the leading authorities of the whole of the London hospitals. We are taking an early opportunity of doing this, and the meeting will be announced in the course of a few days.

Other important announcements will be made at this meeting, which we hope will satisfy both the hospitals and the Press as to the genuine work of the fund.

I am, Sir, yours truly,  
THE HOSPITAL PENNY FUND,  
M. H. GOLDMAN, Secretary.

13 Henrietta Street, and 31 Maiden Lane, W.C.  
October 19th, 1904.

[The principal objections, so far as we know, that have been made to this scheme advocated by *Public Opinion*, is that (a) a large percentage of receipts fail to reach the hospitals; (b) a big advertisement is secured for the journal concerned; (c) the Committee is not sufficiently representative either of the medical charities or of the public; (d) the prize system is bad. Without here going into the merits of the case it may be stated broadly that (c) and (d) seem to us the most pertinent points for inquiry.—ED.]

#### Obituary.

ROGER PORTINGTON GOODWORTH, J.P.  
M.R.C.S., L.S.A.

WE regret to announce the death on October 7th of Dr. Roger Portington Goodworth, of Winterton, near Doncaster. Born in 1846, Dr. Goodworth was a son of William Henry Goodworth, a surgeon in the West Riding of Yorkshire. Later he entered the medical school of the London Hospital, whence he took the qualification of M.R.C.S.Eng., L.S.A.Lond., and L.R.C.P.Edin. in 1876, and not long afterwards went into partnership with the late Mr. Sadler of Winterton. Dr. Goodworth was appointed a Justice of the Peace for the County of Lincoln, and also served for some years upon the County Council. In politics he was a Conservative, while he was a strong supporter of the Established Church. A man of wide sympathies, he has left a large circle of friends and patients to lament his loss. He is succeeded by Frederick Henry Hand, M.D., M.R.C.S.

DR. FREDERICK HENRY HUME.

DR. FREDERICK HENRY HUME, of Islington, who died early last month, devoted the greater part of his professional career to work in that neighbourhood. A student of St. Thomas's Hospital Medical School, he became M.R.C.S.Eng. and L.S.A. in 1864, and graduated M.D. some twenty years later at St. Andrews. He was a man of great energies, and held a large number of appointments, which he conscientiously attended to until a few years ago, when he became crippled with gout.

DR. JAS. B. RUSSELL, OF EDINBURGH.

THE death has occurred, at Edinburgh, of Dr. James Burn Russell, in his sixty-seventh year. He graduated at the University of Glasgow in 1858, and was elected a Fellow of the Glasgow Faculty of Physicians in 1869. For many years he held the office of Public Officer of Health at Glasgow, and was the first to bring into prominence in that city the question of the housing of the poor. Six years ago he left Glasgow for Edinburgh, when he was appointed medical member of the Local Government Board for Scotland.

#### Medical News.

Royal College of Physicians of Ireland.

At the stated annual meeting of the Royal College of Physicians of Ireland, held on St. Luke's Day, the following officers were elected for the coming year:—

President.—W. J. Smyly, M.D.

Vice-President.—E. E. Lennon.

Censors.—E. E. Lennon, Alfred R. Parsons, M.D., J. H. R. Glenn, M.D., W. R. Dawson, M.D.

Additional examiners to take the place of an absent censor or examiner.—Medicine: W. J. Thompson, M.D.; Midwifery: W. C. Nevill, M.D.; Medical Jurisprudence and Hygiene: A. Nixon Montgomery.

Examiner for the Licence to Practise Midwifery.—A. J. Horne, Henry Jellett, M.D.

Examiners for the Membership.—Clinical: J. Magee Finny, M.D., E. E. Lennon; Practice of Medicine: Walter G. Smith, M.D., Alfred R. Parsons, M.D.; Pathology: H. C. Earl, M.D., A. C. O'Sullivan, M.D.

Additional Examiners under the Conjoint Examination Scheme.—Biology: E. MacDowel Cosgrave, M.D.;



Chemistry: Professor Lapper, N. M. Falkiner, M.D.; Physics: George J. Peacocke, M.D.; W. A. Winter, M.D.; Pharmacy, *Materia Medica*, and Therapeutics: H. C. Drury, M.D., Martin Dempsey, M.D.; Physiology, H. C. Earl, M.D.; Pathology: A. C. O'Sullivan, M.D.; Medicine: J. Murphy, R. Travers Smith, M.D.; Hygiene and Forensic Medicine: Henry T. Bewley, M.D.

*Examiners for the Conjoint Diploma in Public Health.*—Meteorology, Sir John Moore, M.D.; Hygiene: Henry T. Bewley, M.D.; Chemistry: Professor Lapper.

*Extern Examiners in Preliminary Education.*—Professor W. E. Thrift, F.T.C.D., Mr. William Kennedy F.T.C.D.

*Representative on the General Medical Council.*—Sir John Moore, M.D.

*Representatives on the Committee of Management.*—J. M. Finny, M.D., Walter G. Smith, M.D., James Craig, M.D.

*Treasurer*, H. T. Bewley, M.D.; *Registrar*, James Craig, M.D.; *Librarian*, R. G. J. Phelps; *Architect*, A. E. Murray, C.E.; *Law Agents*, Messrs. Stephen Gordon and Son; *Agent to the Trust Estate*, C. U. Townshend, J.P.

Dr. J. A. Matson, Dr. T. P. C. Kirkpatrick, and Dr. F. C. Purser were elected Fellows of the College.

In the evening the annual banquet of the President and Fellows took place in the College Hall.

#### The New President of Queen's College, Cork.

As we go to press, it is officially announced that Dr. Bertram Coghill Windle has been appointed to the Presidency of the Queen's College, Cork, in succession to Sir Rowland Blennerhassett, Bart., who has resigned. Professor Windle is a distinguished Irishman. He was educated at Trinity College, Dublin, and subsequently held different anatomical posts in Ireland and England, until finally he was elected Professor of Anatomy in the University of Birmingham. He is also a member of the General Medical Council.

#### Royal College of Surgeons of England.

NOTICE will be found in another column of the annual meeting of Fellows and Members of the College, which will be held on Thursday, November 17th, at 3 p.m. when a report from the Council will be laid before the meeting. Fellows and Members can obtain copies of the report on application to the Secretary, and can, if they so desire, register their names as wishing to receive the Report annually. A printed copy of the agenda will be issued to any Fellow or Member who may apply for one on or after November 14th.

#### French Asylum Scandal.

A SENSATIONAL case will shortly come before the Paris Courts in which revelations are expected regarding the conduct of lunatic asylums. An action is being brought by M<sup>me</sup>. Pierron against her husband for illegal detention in an asylum. The Pierron couple were always quarrelling, and it was alleged that M. Pierron got a lunacy certificate signed by Dr. Laurens, and then informed the police, who, in face of the certificate, ordered the lady to an asylum. After three days, however, the medical officer of the asylum, Dr. Garnier, examined her, and pronounced her to be sane. She was accordingly released, but meanwhile the husband had sold up the home and disappeared. After a long illness, brought on by her sufferings, M<sup>me</sup>. Pierron commenced an action, Dr. Laurens being sued also for complicity.

#### Largest Hospital in the World.

THE new infirmary in Berlin promises to be the largest hospital in the world. When finished next year it will contain 2,000 beds. In connection with the hospital which will be known as Rudolph Virchow's Krankenhaus, there will be a pathological and anatomical institute, a medico-mechanical institute, a magnificently-appointed pharmacy, and a separate house for Röntgen-ray appliances. The entire staff of physicians, nurses and servants will number 650. There will also be a school for training nurses. The largest hospital at present in Germany is near Hamburg, with 1,630 beds. The new hospital will not only be the largest in the world, but its builders boast

that from hygienic and sanitary points of view it will surpass all others, both in Europe and America.—*Chronicle.*

#### Awards at the St. Louis Exhibition.

GRATIFYING evidence of the recognition extended to British commercial enterprise is furnished by the honours awarded by the Committee of the St. Louis Exhibition to Messrs. Burroughs Wellcome and Co.'s exhibit of "Wellcome" Brand Chemicals, "Tabloid" and other pharmaceutical products, and "Tabloid" and medical equipments. Three grand prizes and three gold medals have been conferred for the scientific excellence of these products. The same firm has also been awarded for its Wellcome Chemical Research Laboratories the distinction of a grand prize and three gold medals, in recognition of the importance and educational value of the chemical and pharmacognosical researches conducted in these laboratories under the direction of Dr. Frederick B. Power. Also one grand prize and one gold medal for the Wellcome Physiological Research Laboratories for bacteriological research and preparations, and for educational work. The Grand Prix has been awarded to the Apollinaris Company, Limited, for the Apollinaris natural mineral water.

Mr. Wm. Martindale, manufacturing chemist, of London, has been awarded a Silver Medal for his exhibit of fine chemicals, pharmaceutical products and emergency preparations, Galenical and surgical.

#### The Royal Waterloo Hospital for Children and Women.

THE Royal Waterloo Hospital for Children and Women is being rebuilt and enlarged, and is now rapidly approaching completion. The following have recently announced their gracious intention of becoming patrons of this Institution:—T.R.H. the Duke and Duchess of Connaught, H.R.H. Princess Henry of Battenberg, H.R.H. Princess Frederica Baroness von Pawel Rammingen, T.S.H. Prince and Princess Alexander of Teck, H.R.H. the Grand Duke of Hesse, H.R.H. Prince Charles of Denmark, H.R.H. Princess Charles of Denmark, H.R.H. the Crown Princess of Greece. The above list is in addition to T.M. the King and Queen, T.R.H. the Prince and Princess of Wales, H.R. and I.H. the Duchess of Saxe-Coburg and Gotha, H.R.H. the Princess Christian of Schleswig-Holstein, H.R.H. The Duchess of Albany, and H.M. the Queen of the Hellenes, who for many years have most graciously given their patronage and support.

#### Jervis Street Hospital, Dublin.

At a meeting of the Governors of this Hospital, on October 17th, Mr. Mathew Burke Savage was unanimously elected physician to the hospital in the room of Dr. W. J. Martin, who has resigned, and Mr. J. F. L. Keegan, surgeon to the hospital, in the room of the late Dr. J. J. Cranny.

#### King Edward's Coronation National Fund for Nurses.

A MEETING of the Council of the above society was held on the 12th inst. The Right Hon. the Earl of Meath, President of the Council of Management, presided. The hon. treasurer's accounts for the quarter ending October 11th were read and passed, and applications for membership from nurses were considered and confirmed. The hon. secretaries drew the attention of the council to the fact that the subscription of the nurses as members and the interest of the money invested was not sufficient to allow the society to render help as freely as it would wish to those nurse members who are incapacitated through ill-health. The council appointed a sub-committee, consisting of Sir Andrew Reed, K.C.B., Sir William Thomson, C.B., F.R.C.S., Mr. Andrew Beattie, D.L. and hon. secretaries with power to add to their number, to consider the matter.

WE regret to learn that Dr. Hewetson, of Reigate, was seriously injured in a motor-car collision on Monday. Both he and his servant were thrown violently to the ground, and on examination by Dr. Ross to whose house he was taken, it was found that he had received such injuries internally that it was impossible to remove him. The servant was also cut about the legs, and the car was smashed.

## 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.

**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 VERNON HARCOURT INHALER.

A correspondent has drawn our attention to a recent death under chloroform at University College Hospital. He writes as follows:—"What about the Vernon Harcourt Inhaler? The Hospital where this case actually occurred, being the home of that apparatus, it would be interesting to learn has it been used in that case? If not, why not?" The newspaper cutting enclosed by our correspondent did not state how the chloroform was administered. It would be interesting to ascertain the point, which no doubt would be readily done by the hospital authorities. The question of safety in anaesthetics is one of supreme importance and the inventor of the appliance in question is far too scientific a man, to treat adverse facts—if present—in anything but a spirit of absolute candour.

**STRATHCONA'S HORSE.**—A correspondent, R.A.M.C., asks if any special prevalence of alopecia areata has been noted in connection with the late South African War. In reply it may be stated that a dermatologist whom we have consulted has met with a large number of cases. The wearing of close fitting uniform caps, sometimes for weeks together, and the difficulties in the way of personal cleanliness would, to a great extent, account for the existence of the malady in unusual amount. Enteric fever would be another predisposing factor.

**L.S.A. (Bournemouth).**—The enterprising Bournemouth firm that offered twenty per cent. commission to all clergymen upon sales of "Dr. Auzona's Remedy for Gout," may now learn the composition of that vaunted specific. An analysis of the nostrum, recently published in the *Pharmaceutical Journal* shows it to consist mainly of syrup of buckthorn and citric acid. In a medical journal further comment is unnecessary. A prosecution for fraudulent pretences in representing a compound of that kind as curative of gout might conceivably be sustained in a court of justice.

**ANTI-QUACK (Wandsworth).**—We understand that in New York, the public is becoming alarmed by the enormous extent of the spurious drug business. Chemists complain that the revelations have led to a general decline in their legitimate business. Amongst the incriminating papers seized is a circular for druggists' use, containing a list of thirty-seven drugs and illegal articles put up to imitate genuine and vastly more expensive goods. It is only a matter of time for any thinking and self-respecting country to realise and exterminate this cruel industry. Great Britain is now the dumping ground of American quacks.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 26th.

**HUNTERIAN SOCIETY** (London Institution, Finsbury Circus, E.C.).—8 p.m. Exhibition of Cases. 8.30 p.m. Clinical Evening.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.). 4 p.m. Mr. M. Ollier; Clinique. (Surgical.) 5.15 p.m. Sir A. D. Fripp: Recent Variations in the Technique of Certain Common Operations.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (North-Eastern Fever Hospital St. Ann's Road, N.).—2.30 p.m. Dr. H. Cuff: Demonstration on Fevers.

THURSDAY, OCTOBER 27th.

**BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY** (20 Hanover Square, W.).—8.30 p.m. General Meeting. 9 p.m. Presidential Address:—Dr. W. B. Davies: The Spa Treatment of Arthritis Deformans.

**NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM** (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Clinical Meeting. Exhibition of Clinical Cases.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. W. Ewart: The Preventive Treatment and the Protective Treatment of Chronic Heart Disease.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. J. E. Squire: The Arrest of Pulmonary Tuberculosis (demonstration of cases). (Post-Graduate Course.)

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture.—Dr. A. Giles: Diagnosis of Pelvic Tumours.

FRIDAY, OCTOBER 28th.

**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. Mr. N. Maclehoze: Clinique. (Eye.)

## Vacancies.

**Bury Infirmary.**—Junior House Surgeon. Salary £200 per annum, with board, residence and attendance. Applications to the Hon. Secretary, Dispensary, Knowley Street, Bury, Lancashire.

**Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C.** Senior House Surgeon. Salary £100 per annum, with board and residence in the Hospital. Applications to Robert J. Bland, Secretary.

**Down District Lunatic Asylum, Downpatrick.**—Jun. Male Assis. Med. Officer. Salary £100 per annum, with furnished apartments, &c. Applications to the Resident Medical Superintendent.

**The Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Norwood, Middlesex.**—Senior Resident Medical Officer. Salary £100 per annum. Applications to William Morton, Secretary, 7 Fitzroy Square, W.

**London County Council Asylum, Horton, Epsom.**—Fourth Assistant Medical Officer. Salary £180 per annum, with board, furnished apartments and washing. Applications to E. W. Partridge, Asylum's Committee Office, 6 Waterloo Place, S.W.

**City of London Asylum, near Dartford, Kent.**—Medical Superintendent. Salary £200 per annum, with unfurnished house, coal, light, laundry and garden produce. Applications to Charles Fitch, Clerk to the Visiting Committee, Guildhall, E.C.

**Parish of St. Marylebone Infirmary, Rocham Street, Ladbrook Grove Road, Notting Hill, W.**—Male Assistant Medical Officer. Salary £110 per annum, with furnished apartments, ration, and washing. Applications to Henry T. Dudman, Clerk to the Board, Guardians' Offices, Northumberland Street, Marylebone Road, W.

**Warneford Hospital, Leamington.**—House Surgeon. Salary £100 per annum, with board, washing, and apartments. Applications to G. T. Poole, Secretary.

**Nottingham Children's Hospital.**—House Surgeon. Salary £100 per annum, with board and residence. Applications to A. F. Kirby, Secretary, Albion Chambers, King Street, Nottingham.

## Appointments.

**CLARKE, W. ST., M.D.** Toronto, Clinical Assistant to the Chelsea Hospital for Women.

**COLBRIDGE, A., M.R.C.S., L.R.C.P.Lond.**, Clinical Assistant to the Chelsea Hospital for Women.

**CUMMINGS, WILLIAM, M.B., B.Ch., B.U.I.**, Physician to the Cleveland Hydropathic Institution, Somerset.

**GIDDINGS, G. T., M.D.** Durh., Public Vaccinator of Beckenham.

**LITTLE, E. M., F.R.C.S. Eng.**, Honorary Assistant Medical Officer to the Southport Infirmary.

**LLOYD, W. GIBBS, M.Sc., M.B., Ch.B.** Vict., Medical Officer and Public Vaccinator to the Walton Workhouse Infirmary, Liverpool.

**NUTTALL, J. S. W., M.B., Ch.B.** Vict., Assistant Medical Officer to the Walton Workhouse Infirmary, Liverpool.

**SMITH, E. CASSIUS, M.B., Ch.B.** Glasg., House Surgeon to the Victoria Hospital for Children, Chelsea.

## Births.

**COPLEY.**—On October 14th, at Palace Street, Drogheda, the wife of Dr. S. Copley, of a daughter.

**JAMES.**—On October 18th, at Hungerford, Berks, the wife of Robert Blake James, M.R.C.S. Eng., L.R.C.P.Lond., of a son.

**LING.**—On October 20th, at 12 Harley House, London, the wife of Maurice E. Ling, M.D., of a son.

**SWALES.**—On October 18th, at Oak Villa, West Kirby, Cheshire, the wife of Edward Swales, M.R.C.S., L.R.C.P.Lond., of a son.

## Marriages.

**COFFEY—FITZGERALD.**—On October 18th, at Mitchelstown, by the Rev. P. Casey, of St. Colman's College, Fermoy, assisted by the Rev. William Casey, P.P., abbeycale (both cousins of the bride), the Very Rev. Canon Rice, P.P., Mitchelstown, Rev. T. O'Donoghue, Rev. Father Flannery, and the Rev. O. W. Ellard, Dr. Edward R. Coffey, 14 Westbourne Place, Queenstown, and late of Farnham, Surrey, to Nellie Teresa, only daughter of Mr. Patrick Fitzgerald, Mitchelstown.

**FOSTER—WATSON.**—On October 22nd, at St. Peter's, Bayswater, William, second son of the late Birkett Foster, member of the Royal Society of Painters in Water-colours, to Mary, daughter of the late William Watson, M.R.C.S., of Lancaster.

## Deaths.

**BISHOP.**—On October 22nd, at The Platts, Watford, Georgina Elreia, widow of the late Thomas Bishop, Esq., of Bramcote, Notts, and daughter of the late John Pidcock, Esq., M.D., of Watford, in her 98th year.

**KELSON.**—On October 18th, at his residence, Beckington, Guernsey, Frederic Hughes Kelson, M.R.C.S.L., formerly of Ceylon, in his 86th year.

**MOORE.**—On Sunday, October 23rd, at his residence, 29 Upper Merrion Street, Dublin, Robert Henry Moore, F.R.C.S.I., in his 89th year. Funeral private. No flowers, by request.

**SLACK.**—On October 24th, at Derwent Hill, Keswick, Anne Aintworth Slack, widow of the late Robert Slack, M.D. aged 71.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, NOVEMBER 2, 1904.

No. 18.

## Paris Clinical Lectures.

### TAPPING OF THE LUMBAR REGION.

By DR. G. MILIAU,

Chef de Clinique de la Faculté à l'Hôpital St. Louis.

[SPECIALLY REPORTED BY OUR FRENCH CORRESPONDENT.]

UNDER the name of lumbar puncture is designed a little operation, consisting in piercing the dural cul-de-sac by a trocar and giving issue to the cephalo-rhachidian liquid.

This operation was practised for the first time by Quincke, of Heel, in 1890. This author inserted his trocar into the third or fourth lumbar space in the middle line in children, and half an inch to the right of this line in adults. It was Chipault who recommended the puncture to be made between the fifth lumbar vertebra and the sacrum, for the reason that this space is larger than those between the lumbar vertebrae, and that it corresponds to the most dilated portion of the subarachnoid cul-de-sac. In this space also there is less risk of wounding the caudal nerves. Tuffier, however, who was a great partisan of anæsthesia by cocaine injected into the medulla, preferred the fourth lumbar space as more easy to find, it being situated exactly on the line drawn between the two iliac crests.

*Operation.*—To puncture the lumbar space a long and strong platinum needle is used. The pointed extremity is bevelled, while the other is formed so as to adapt itself to a Pravaz syringe. The patient being seated, the body bent forwards, and the arms well in front, after having traced with great care the line joining the two iliac crests and disinfected the region so as to render it completely aseptic, the operator introduces the needle on this line to the right of the vertebral column, and about half an inch of a vertical line drawn between the spinous apophyses. The needle is directed forwards and a little inwards; it passes through successively the skin, subcutaneous cellular tissue, lumbar aponeurosis and the sacro-lumbar muscles. It passes between the two vertebrae, perforates the yellow ligament, and after piercing the membranes it penetrates in the cul-de-sac. Immediately drops of a more or less limpid liquid issue from the free extremity of the needle. Such is in all simplicity the operation of tapping the cephalo-rhachidian liquid.

*Accidents.*—Matters, however, do not always terminate so happily. Obstacles may be met with; accidents may occur which the practitioner should bear in mind. At first, although the different

parts of the operation may have been followed with care, it may happen that no liquid flows out. There has been a "miss." The reasons for this disappointment are various. Instead of piercing the membranes, the needle may have pushed them before it, making a cap of them, so to speak, as has sometimes happened in thoracentesis for pleurisy, or that the needle, having gone too far, penetrated the cauda equina and was not consequently in the cul-de-sac. To overcome these obstacles it is generally only necessary to insert farther or to withdraw the trocar or give it a certain rotary movement. A small clot of blood may block the instrument. In such an event aspiration may be made with a Pravaz syringe. Sometimes also it occurs that the liquid will not come out by reason of want of pressure. By making the patient cough, this accident is remedied.

Besides these accidents, which constitute a simple *contretemps* in the operation, there are others deserving attention. Blood may issue instead of the cephalo-rhachidian liquid by reason of a vein being wounded by the needle, and this sometimes persists. In such case the trocar may be withdrawn and inserted in another place. Care should be taken not to push in the needle too far. M. Abadie recommends one inch in children and two to three inches in adults. After the operation, the patient may complain of rhachalgia; staggering gait, vertigo, convulsions and a rise of temperature have been observed more than once.

Generally speaking, all these phenomena possess but little gravity. Simple rest in bed is sufficient. The same might be said of vomiting, sometimes observed. Attention, however, should be paid to the cephalalgia, which is rarely absent after this operation. It is a sensation of weight accompanied by lancinating pains lasting from a few hours to three or four days. Frequently it is very painful, so that the patient is obliged to remain motionless in bed. It disappears, however, without leaving any trace. Sudden death has been observed after puncture of the cord. This unfortunate termination is announced by a violent headache, respiratory troubles, precipitation, weakness and irregularity of the heart beats, in a few moments the patient falls into coma, the breathing stops and no artificial means are capable of re-establishing it. In the statistics of Gumpecht, seventeen cases of sudden death are registered. It must be said, however, that this accident occurred only in subjects affected with grave lesions of the brain (tumours, ventricular congestion), and in cases where the quantity of the cephalic fluid removed was considerable (two to three ounces). This fatal accident is considered due to a too brusque decompression of the nervous elements. To avoid it,

only a small quantity should be withdrawn, from one to two drachms.

*As a Therapeutic Means.*—When Quincke imagined the lumbar puncture, his idea was to act against affections producing a hypersecretion of the cephalo-rhachidian liquid and an excess of pressure in the cerebro-spinal arachnoid cavity. He practised numerous punctures and others followed his example, but the results have been so contradictory that it is impossible to say if the operation can be considered as capable of rendering real service. We have got no farther than that. In congenital hydrocephalus, the lumbar puncture has replaced that of the lateral ventricles. Repeated tapping, withdrawing from an ounce to two ounces of the liquid, have been practised. Generally, the immediate result is very good, the convulsions disappear, the limbs recover their movements, the sight is improved as well as the psychic functions. But this improvement does not continue, the patient gradually relapses into his former condition. Quincke and Stadelmann have concluded that the operation had little or no effect on the disease. In certain subjects affected with cerebral tumours, it frequently happens that hypersecretion of the cephalo-rhachidian liquid produces compression on the brain and the medulla, provoking headache, optic neuritis, stupor, and epileptiform convulsions. Lumbar puncture has relieved some of these symptoms and might be tried.

In all the varieties of meningitis the operation has been tried in a systematic manner. According to M. Abadie it gives excellent results in that variety which Quincke mentioned under the name of simple serous meningitis. In several cases of syphilitic meningitis it relieved the first symptoms, giving time for the specific treatment to act. But in tuberculous meningitis the results are very contradictory—*nil* in some cases, transitory in others; while in a few they were very encouraging. The headache, which is a very distressing symptom, generally yields to the operation, and for this reason one would be justified in having recourse to it.

Acute uræmia has been also treated by the lumbar puncture. Two typical cases of Dr. MacVail have been already published. Two patients, suffering from the convulsive and comatose form of uræmia in the course of Bright's disease, were cured by the operation. These patients had been already treated by injections of pilocarpine and applications of hot air, but without success. An ounce of the cephalo-rhachidian liquid was drawn off, and under the influence of this intervention the coma yielded, the patients recovered consciousness and the convulsive seizures ceased. On the other hand, the œdema gradually disappeared and the albumin diminished, while the quantity of urine increased.

But the lumbar puncture is not only employed to evacuate simply a certain quantity of cephalo-rhachidian liquid, it is utilised also to introduce therapeutic agents into the subarachnoid spaces, especially since Sicard proved that absorption by this means was superior to the subcutaneous method. In patients affected with tetanus this author injected antitetanic serum, chloride of sodium, to a man suffering from general paralysis, and bromide of potassium to epileptics. Injections of cocaine beneath the arachnoid membrane to produce anæsthesia were imagined by Bier and vulgarised by Tuffier. Many surgeons tried this

method, but with different results, and finally, through grave accidents, it was abandoned.

*Lumbar Puncture as a Means of Diagnosis.*—The lumbar puncture allows the cephalo-rhachidian liquid to be studied in all its characters—chemical, physical, bacteriological, and cytological. In the normal condition, this liquid is clear, colourless, limpid as running water, and gives no deposit when at rest. These different characters can be considerably modified. If the liquid can remain clear in cases of hydrocephalus or of hypersecretion consequent on a cerebral tumour; if it can issue clear but becoming clouded on rest in tuberculous meningitis; if it is discoloured at the outset in coccic meningitis and absolutely purulent in suppurating meningitis, coloured red in fractures of the skull and in a large number of cases of traumatism of the cranium. The bacteriological examination has given the following results: in the normal state the liquid contains no microbe, but in coccic meningitis are found streptococcus, staphylococcus or the pneumococcus; in cerebro-spinal meningitis the diplococcus of Weichselbaum, in tuberculous meningitis the bacilli of Koch, but not always.

The importance of the demonstration of these different agents in the liquid obtained by the lumbar puncture is very considerable as it permits diagnosis of the existence and nature of the meningitis.

*Conclusions.*—From what has been already said tapping in the lumbar region is an operation of easy execution, and if done with care and not too much liquid is withdrawn no accidents will occur. The operation has not given as yet any curative results in the treatment of the different maladies for which it has been employed. But it has afforded important relief to some symptoms—headache, certain pains and cerebral accidents in some cases of uræmia.

In rendering possible the study of the different characters of the liquid in morbid affections, the lumbar puncture is a means of diagnosis, precise and useful in the different cases of meningitis, especially that of a tuberculous nature.

## EDUCATION UNDER THE MIDWIVES ACT. (a)

By EWEN J. MACLEAN, M.D., M.R.C.P.Lond.,  
F.R.S.Edin.,

Lecturer on Midwifery at the University College of South Wales and Monmouthshire; Senior Gynaecologist to the Cardiff Infirmary; Consulting Gynaecologist to the Porth and Mountain Ash Cottage Hospitals.

PRACTICALLY alone among civilised and progressive countries England, until quite recently, has been without a system of registration and supervision of midwives. France, Russia, Sweden, Germany, and Switzerland have long paid much attention to the education and State control of midwives. In Japan the regulations for midwives are very strict. No midwife may attend a case unless she has the *Japanese* certificate. Their written examination lasts four days. When a midwife attends she is supposed to take a pupil with her, so that practically two nurses attend every case. It is true that attention has for many years been called to this anomaly of ours, and since 1890 several Bills have been presented to Parliament, some even passing a second reading; but not until 1902 did a measure dealing with the subject receive the Royal assent.

(a) Inaugural lecture of the Course of Lectures to Midwives, delivered at the University College, Cardiff, on October 24th, 1904.

The delay in legislation has certainly not been due to any lack of material to which that legislation might apply, for it is estimated that throughout the country no fewer than 500,000 women annually are attended by midwives. Probably 33,000 are so attended in South Wales and Monmouthshire.

In *France*, where some form of registration is traceable as early as 1292, the municipalities have taken strong measures to enforce education and supervision of midwives. In *Italy*, where special regulations were issued in 1890, the mortality from child-birth and child-bed has fallen from 235 per million in 1887 to 85 in 1902. In our own country during the same period the mortality has not even fractionally improved. It is estimated that in every ten years we lose 46,000 mothers in child-birth, and half of this appalling total of deaths is caused by puerperal fever—a disease for the most part preventable. The average mortality from puerperal fever and accidents of child-birth for England and Wales was 4.7 per 1,000 births; for London, 3.9; while that for South Wales was as high as 6.1.

But it may be asked whether these high mortality-rates have any special reference to midwives. The assertion is rendered probable from the fact that an average proportion of 60 to 70, or even in some districts as many as 90, per cent. of the confinements are attended by midwives. It is rendered practically certain when we remember that in lying-in institutions, where vastly improved methods are in vogue, the child-birth mortality has been markedly reduced. In other words, the practice of the midwives, which covers so overwhelming a proportion of the labours throughout the country, has not been brought into line with the more enlightened methods which the advance of science has placed in our hands.

Let it be emphasised here that there *can* be no attempt to abolish the calling of the midwife. Midwives are a necessity for the poor, and for many of the mothers of the working classes who cannot afford a doctor's fee. The advantages of instruction and supervision should long ago have been placed within her reach, and it is in order that malpraxis may be checked and that effective knowledge may be added to kindness of service that this new legislative measure has been brought into operation. The practice of existing midwives must be levelled up and those who intend to follow this calling must now show evidence of at least a moderately efficient training and knowledge.

The Midwives Act has formulated a central authority in London and throughout the counties and county boroughs of England and Wales, local authorities, for the purpose, as stated in the preamble, of securing "the better training of midwives and to regulate their practice." The central authority, known as the Central Midwives Board, is charged with the carrying out of all the provisions of the Act with the approval of the Privy Council. These duties include the regulation of the course of training of midwives, the issue of certificates after examination, the annual publication of a Midwives' Roll, and the regulating, supervising, and restricting within due limits the practice of midwives. The Act, it may be here noted, applies only to England and Wales.

After April 1st, 1905, no woman will be able to style herself a midwife unless certified under the Act. The penalty is a fine not exceeding £5. After April 1st, 1910, no woman will be allowed to practise for gain as a midwife unless certified, under a penalty not exceeding £10. These provisions do not affect the case of one rendering assistance in emergency nor the practice of those attending confinements under the direction of a doctor. Up to March, 1905, claim to be certified may be made by those holding a certificate in midwifery from the Royal College of Physicians of Ireland, the Obstetrical Society of London, the Coombe Lying-in Hospital, and Guinness's Dispensary, the Rotunda Hospital, or such other certificate as may be approved by the Central Midwives' Board. Further, women who can satisfy the Central Board that they have been in

actual practice as midwives for at least one year prior to July 31st, 1902, and that they bear a good character, may claim to be certified under the Act. Those who do not come within one of these categories are required to pass the examination of the Central Midwives Board before obtaining a certificate, and their names will be entered on a separate Roll. The first of these examinations will be held in July, 1905.

But whilst this central controlling board exists, the keynote of the practical efficiency of the Act is devolution. Every Council of a county or a county borough throughout England and Wales is the local supervising authority over midwives. These bodies, however, can delegate their duties to committees or to the district councils if they think proper. Such committees may consist wholly or partly of members of the Council, and women are eligible to serve on the committees.

The local authorities appoint an executive officer, and the medical officer of health is, from his position and knowledge of administration, eminently fitted to serve in that capacity. In the great majority of instances, the medical officer of health has been so appointed.

The local authority exercises general supervision over all midwives practising within the area of the county or county borough, and has to investigate charges of malpractice, negligence or misconduct, and report the same to the Central Midwives Board.

Every certified midwife must, before commencing to practise, give notice in writing to the local authority of her intention, and must repeat the notice in January of each year during the period in which she continues to practise. She must give every facility to the local authority, and their executive officer, for carrying out supervision, and she will be prohibited from engaging in any unhealthy occupation.

Dr. Ward Cousins, of Portsmouth, in an interesting paper on the Midwives Act, (a) notes that in Sweden the midwife has to be examined every year by the medical officer of health, and should her knowledge be found deficient on any material subject, she can be suspended from practice for a time.

Under the Act, the midwife is permitted to attend normal labour only, and she is compelled to send for a qualified registered practitioner in every emergency. The course of training and the subsequent examination will deal specially with the recognition of danger and abnormality in either mother or child.

The midwives in *Switzerland* are required to make a solemn affirmation on receiving their certificates. They promise on oath to practise their profession with reverence, patience, and earnest endeavour, and, on every occasion, to send for a physician in all abnormalities. For exceeding her sphere of practice the midwife is liable to a fine of from 10 to 1,000 francs.

Under an Act, upon the medical man who is called in by the midwife upon the occurrence of certain symptoms falls the duty of notifying puerperal fever and other infectious disorders. The midwife does not diagnose the disease, but sends for the doctor. Information of all cases of fever should be forwarded at once to the local supervising authority. The record of the midwife will show the number of cases which have occurred in her practice and the name of the doctor who assisted her.

After any attendance upon a case of puerperal fever or any other disease supposed to be infectious, the midwife must disinfect herself and her appliances and have her clothing thoroughly disinfected before going to another case, and the local supervising authority may suspend a midwife from practice if suspension appears necessary to prevent the spread of disease.

Dr. Ward Cousins, in the address from which I have quoted, says: "I believe that the work of the midwives in promoting reform in the houses of the poor will have a wide and wholesome influence. . . . I think it is not too much to hope that indirectly the silent work of educated midwives will prove a wholesome

(a) Annual meeting of the British Medical Association, 1903.

stimulus to the higher classes of society and arouse their sympathy in the great work of improving the dwelling-houses of the labouring classes of our country.

From the foregoing short statement it is evident that the efficacy of the measure will depend in large part on the thoroughness with which the various local supervising authorities carry out its administration; and, further, whilst many strict regulations as to supervision and practice are given, much is left to local initiative in providing the education needed for the new class of midwives which the Act will create. It will be appropriate here to remind midwives that it will be to their interest to acquaint themselves fully with the new conditions under which they must now work. It is not enough for them to become certified merely and to continue to practise on the same lines as heretofore. They should consider the advisability of attending a course of lectures where their duties are taught and their responsibilities defined. The Central Midwives Board include this as an important section in a recognised course of lectures. The executive officers of the various local authorities are doing all in their power, by printed notices and other literature, to bring these points under the notice of midwives.

As to the training of pupil and of practising midwives who wish to bring themselves into line with the standard of knowledge required by the Act, various centres are being established. Birmingham and Manchester, for instance, are building large maternity hospitals to which out-patient departments will be attached.

As to our own locality, the course of lectures we inaugurate to-day is the outward and visible sign of the determination of the supervising authorities of the county and borough to deal with the problem of the efficient education of midwives. It is to the point to say that if that problem be solved in South Wales, it may be solved anywhere. It is appropriate, therefore, that we should be the first in the field, for this course of lectures in connection with the medical faculty of the University College is the first of its kind in the Kingdom. Its establishment has met with the warm approval of the Central Midwives Board, and others are likely to follow the example.

In January of this year, Dr. Walford, the able medical officer of health for the county borough, in a paper on "The Local Administration of the Midwives Act," suggested that steps should be taken to form a local training centre for midwives. The suggestion was acted upon, and the Committee formed in connection therewith were supported by Principal Griffiths, by Dr. T. H. Morris, Chairman of the County Education Committee, and by Professor Hepburn, Dean of the Medical Faculty, and the course was made conditional to certain financial grants, and those who are most concerned—namely, the working classes and the poor—will be grateful for the public spirit shown by the contributing councils. The Glamorgan County Council make an annual grant of £100 and have the power to nominate twenty-one candidates for free studentships. The Cardiff County Borough Council give a grant of £50 per annum and claim the nomination of nine free students.

When we turn to discuss the practical training we are met by an aspect of the question which is not without difficulty. A candidate for examination must bring evidence not only of having attended a recognised course of lectures, but also of having attended personally twenty cases under the supervision of a qualified practitioner or of a certified midwife recognised by the Board or in connection with a recognised institution.

The question will naturally be asked, How, when, and where may this experience be obtained? Unless the change from the old order to the new is to be a more gradual process than the provisions of the Act would lead one to suppose, it is clear that all available cases must be utilised. In all probability the busy qualified practitioner will have little time for the necessary supervision. The bulk of the certification as to attend-

ance on cases will be effected by recognised certified midwives and by institutions. It would, of course, be desirable that qualified medical practitioners should give the time for supervision, but the probabilities do not lie in that direction.

Doubtless, in course of time, and in pursuance of the law of supply and demand, midwives vested by the Board with the power of certification will become established in the outlying districts, but pupils desirous of becoming eligible for examination within a reasonable period of time will naturally seek their experience in the more populous centres and large towns. The rural districts, however, will assuredly supply a considerable number of the cases.

In this connection it is permissible to refer to the fact that the Cardiff and District Branch of the Q.V.J. Institute have already added a maternity department to their work. That department will be recognised by the Central Midwives Board for the practical training of pupil-midwives. The cases will be attended under the supervision of experienced certified midwives and of the Superintendent of the department.

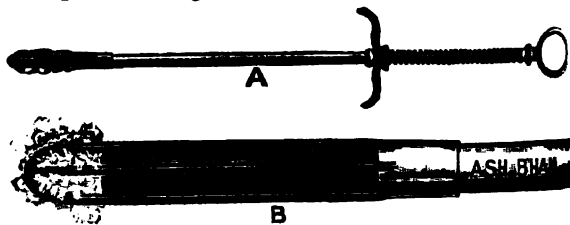
It is anticipated that in January of next year, *i.e.*, in three months time, the department will be separately housed and ready to undertake the practical training of a certain number of non-resident and of resident pupil-midwives.

Such, in outline, is the information which, up to the present, I am able to put before you. As we are practically the first to carry a scheme of the kind into operation, our work and experience will be watched by other centres in the country, and those of us who are associated in the educational aspect of the Midwives Act are resolved that no effort on our part shall be spared to give the best possible effect to the provisions of a measure which so nearly concerns the welfare especially of the working classes and the poor, and also, in a wider sense, of the community as a whole.

## A COMBINED UTERINE APPLICATOR AND BLUNT CURETTE IN GYNÆCOLOGY.

By ALEXANDER DUKE, F.R.C.P.I.

For those gynæcologists who prefer the application of liquid escharotics to the cervical canal and uterine cavity, as in cases of cervicitis, chronic endometritis, &c., the instrument depicted will, I think, be found useful, combining two instruments in one, and devoid of the defects common to all other "applicators" with which I am acquainted. The illustration represents a combination of my "cervical curette," designed for the removal of cervical mucus and various secretions filling up and hanging from the cervix and os, with the ordinary probe or applicator, not to be used by wrapping cotton wool round, but as a sliding piston to compress cotton wool, or bit of round lamp-wick placed in cage.



After the use as curette (A) and when well cleansed, the cage is unscrewed, and a piece of either absorbable cotton wool or round lamp-wick inserted; the cage is then screwed on, dipped in the escharotic



chosen and introduced into the uterus. The pressure of thumb and support of fingers on side-rests will push up central rod and the contents of cotton wool or wick be extruded where required.

Advantages claimed — (1) Surface cleaned by the curette (rotary action) prepares it for the application of the caustic (which is not, as often happens, absorbed by discharge or squeezed out by contraction of cervix on armed probe alone, and so practically useless); (2) no fluid can be squeezed out of cotton wool or lamp-wick by contraction of cervix, the wire cage effectually preventing this; and (3) free exit for any excess of caustic fluid during withdrawal of applicator, the contents of cage just mopping surface; no dribbling if contents of cage be properly charged. By the use of my combination instrument the cure of chronic endometritis, &c., will be hastened, the choice of escharotics being left to the judgment of the operator, as each case must be treated on its own merits.

## NUTRITION IN WASTING DISEASES OF CHILDREN AND ADULTS.

By DAVID WALSH, M.D. Edin.,

Senior Physician, Western Skin Hospital, London, W., &c.

OF recent years there has been a marked tendency to lessen the use of drugs in the treatment of not a few diseases. As we all know, many complaints formerly treated by physic are now forthwith handed over to the operating surgeon. In a host of other maladies the medical man nowadays turns for aid to physical methods, such as the "high frequency" electrical current or hot air baths, or to the old-fashioned remedies of good food, travel, exercise, pure air, and sea-bathing. In the present article the chief point that will be dealt with is that of food-nutrition in relation to wasting disease.

The subject was suggested to the writer by various medical friends, who reported excellent results in such cases from the use of a particular food, Sanatogen. On inquiry, I found that the nutrient product in question had, during the past five years or so, been extensively used in Germany, where it had been favourably spoken of by many eminent men, including Professors Ewald, Tobold, Neisser, Walther, von Schroetter, Duhrssen and others. Their results, published in various medical journals, were so remarkable as to suggest a kind of specific nutrient value in this new food. On further reference I found that Sanatogen was being advertised in the *Lancet*, *British Medical Journal*, *Medical Press and Circular*, and other leading professional journals. There could be no doubt, therefore, as to its acceptance and standing in the medical world. At the same time it seemed desirable to learn more as to its qualities by a systematic clinical investigation. Accordingly, it was determined to put the matter to a careful trial. This has been done in a series of selected cases, some of them taken from private and others from hospital practice, in which all details have been accurately noted. My results, briefly stated, have confirmed those of the above mentioned Continental observers. They have been sufficiently striking to warrant the belief that in Sanatogen we have a nutrient food of more or less specific absorbability into the system,

and hence of considerable nutritive value in all cases of acute or chronic tissue starvation.

The composition of Sanatogen is stated to be 95 per cent. of pure casein (milk albumin) with 5 per cent. of glycerophosphate of sodium. Many foods have [an apparently equal nutritive value, but every medical practitioner knows how difficult it is to nourish a patient suffering from disease-emaciation. The wasted body remains wasted in spite of abundant feeding with eggs, milk, peptonised foods, meat extracts, and the round of invalid diet. Do we not all recognise the fact that the starving tissues are fed, not by the food swallowed by the patient, but by the amount of nutrient matter absorbed by the gastric and intestinal mucous membrane? If we could ensure the absorption of nutriment into the blood, the problem of nutrition in disease would be reduced to a matter of mere chemistry and mechanical feeding. Failing that somewhat remote contingency, it is conceivable that some way may be found of preparing a foodstuff as to render it readily absorbable in the alimentary canal, no matter how disturbed and weakened the digestive functions may have become. Judging from clinical results, Sanatogen appears in many cases to possess some such power of ready absorbability, without which the richest foodstuff represents simply so much foreign matter in the stomach and intestines. My own experiences are here recorded as a simple extension and confirmation of the remarkable statements of the distinguished Continental authorities already cited. It is to be hoped that medical men here in the United Kingdom will ascertain for themselves the value of this dietetic remedy in wasting diseases, in convalescence, and, indeed, wherever there is evidence of general malnutrition.

A certain number of the cases experimented upon were those of wasting children, or "wasters," as they are technically called. One of the greatest difficulties with which the physician can be faced, either in hospital or in private practice, is to restore the general nutrition of these little patients. In spite of the utmost care in the regulation of diet the mortality among these children is extremely high. The wasting is obviously a sign of defective nutrition, and the loss of body-weight persists regardless of the quantity or quality of the food introduced into the stomach.

The explanation is probably that nutrient matter is not absorbed because of some atrophy or imperfect development of the structure or functions of the glandular and absorptive apparatus of the stomach and intestines. Wasting from insufficient food may be taken as the simplest form of infantile atrophy. General tissue starvation may also be due to the taint of tubercle, especially in the form of *tabes mesenterica* or of syphilis. Rickets is another predisposing cause, although, happily, it is becoming much less frequent nowadays. Other causes, again, are "fevers" and various invasions by pathogenic organisms.

The prominent symptoms of almost all forms of infantile wasting are, diarrhoea, vomiting and anæmia. The chief point about the *wasting* is its persistency—repeated weighing reveals no increase in weight. The *diarrhoea* is a constant symptom, with stools that are as a rule green and offensive, but at times they are yellow with greenish streaks. The *vomiting* is persistent and

urgent, and occurs immediately after food of any kind whatever. The *anæmia* is characterised by erythrocytes of not more than two millions to the cubic millimetre, while the *leucocytes* are increased to, say, 12,000, and the hæmoglobin value may be anything between 36 and 64 per cent. These patients are apt to get pneumonia, usually of the broncho-pneumonic but sometimes of the lobar variety.

In looking for the cause of infantile wasting with the above train of symptoms, the physician will naturally note any past or present evidence of "snuffles," rash, delayed closing of fontanelles, or of any of the various bony or glandular changes associated with tubercle, rickets, or syphilis. Whether specific drugs be or be not required, it goes without saying that dietetic treatment must always be of first importance in such conditions. My own experience of Sanatogen, as shown in the appended cases, is that it stays the diarrhoea—ten or twelve motions a day are thereby reduced to one or two; it stops the vomiting, and it improves general conditions and causes the patient to put on flesh. Finally, it brings about some amount of improvement in the coloured corpuscles, which increase at the rate of about 10,000 per c.mm. daily. These results, due, as I believe they are, to such simple means, are worthy of the careful attention of every medical man who is called upon to deal with wasting diseases.

*Case I.*—A. B., male child, æt. one month; brought to hospital with a history of diarrhoea, vomiting and wasting from birth. There were usually from eight to ten green, slimy and offensive motions in the twenty-four hours. The child had "snuffles," and was covered with a syphilitic rash all over the body. It was breast-fed, but a little cow's milk diluted with one-third lime water had been given from time to time. The weight was only 4½ pounds. Treatment included grey powder, inunctions of mercurial ointment, and the administration of subnitrate of bismuth, both in small and in large doses. The incessant vomiting, however, went on unchecked, and, humanly speaking, there seemed to be not the least chance of recovery. At this point all medicinal treatment was discontinued, and the infant ordered a teaspoonful of Sanatogen in a mixture of milk and cream every four hours. This combination was taken well, and in less than twenty-four hours the vomiting and diarrhoea had ceased. The child gained half a pound in weight in a week, and made a good recovery.

The foregoing case speaks for itself. It has an extremely suggestive value as regards the relation of general nutrition to the curative action of specific drugs upon the body. The following case illustrates the use of Sanatogen in stopping diarrhoea and vomiting in a wasted child, where there was no evidence of any specific disease.

*Case II.*—C. D., a female child, æt. four months; brought with a history of almost continuous diarrhoea since birth. There were many motions daily, of a yellow colour streaked with green, and very offensive. Milk, cream, and many kinds of "infant foods" had been tried in vain; nearly all of them excited vomiting. The child weighed only six pounds, was thin and pale, with an irregular temperature ranging between 98° and 101°. There was no evidence of syphilis nor of tubercle. The red blood corpuscles numbered 4,150,000, the leucocytes 11,000, whilst the

hæmoglobin value was 61 per cent. Sanatogen given in two-drachm doses every four hours promptly stopped the diarrhoea and lessened the vomiting. In four days the temperature had fallen to normal, and at the end of a week the red cells had risen to 4,230,000 and hæmoglobin value to 62½ per cent. The treatment was continued for some time, and careful weighing showed that the child gained weight at the rate of about a quarter of a pound a week.

The following cases show the value of this new form of food nutrition in various wasting conditions:—

*Case III.*—F. F., female, single, æt. 18, waitress in a London tea-shop; complaining of palpitation and shortness of breath. For three years she had suffered periodically from attacks of *anæmia* and amenorrhœa. She was liable to fainting fits, especially when actively engaged in a hot room. The conjunctivæ and the mucous membrane of the lips were pale. Her red blood corpuscles numbered 3,500,000 per c.mm., with a hæmoglobin value of 42 per cent. She lived chiefly on tea and bread and butter, and it was only with much difficulty she was able to continue her employment. After relief of constipation she was ordered Sanatogen in milk as a staple article of dietary. This she took without difficulty, and in a fortnight her red cells improved at the rate of 10,000 a day. Her symptoms gradually subsided, and at the end of a month she was able to take her meals with a good appetite, and was free from all appearances of *anæmia*.

*Case IV.*—G. H., a married woman, æt. 36, suffering from melancholia. She had sustained a severe shock from the sudden loss of her favourite child. She took to her bed and practically refused all food with the exception of beef-tea, milk and jelly. She lost weight rapidly, and suffered from profuse sweating at night. No sign of tubercle, however, could be detected in the lungs or elsewhere. She was *anæmic*, and her red corpuscles numbered only 3,800,000 per c.mm., with hæmoglobin 48 per cent. She was placed on Sanatogen, and at once began to improve. Her mental equilibrium was restored, she developed fresh energy, and at the end of a fortnight was able to resume her home duties. Her red cells had by that time risen to 4,000,000 per c.mm. and the hæmoglobin to 52 per cent. The improvement in this case was most striking and suggestive.

*Case V.*—T. J., an elderly widow lady, had suffered for many years from chronic bronchitis and emphysema. Of late she had developed glycosuria; the amount of urine passed in the day measuring on an average six pints, with a specific gravity of 1025. She lost little flesh and there were no other symptoms of diabetes. She had been carefully dieted by a physician, under whose direction all sugar and starch were excluded. Unfortunately, from the state of her teeth she was unable to masticate the various substitutes for bread which were from time to time suggested. Her heart was dilated, and she suffered much from dyspnoea on exertion, even when the latter was slight, such as going slowly upstairs. Flatulence was another great trouble, and eructations were almost incessant. The dietary was relaxed, and she was placed on one-ounce doses of Sanatogen in milk every four hours. In less than a week all her subjective

Symptoms had disappeared, and the urine was free from sugar. Her powers of walking gradually returned, and in a month she was able to walk half a mile on level ground twice a day without much inconvenience.

*Case VI.*—K. L., a girl, æt. 3, brought to me by her mother for advice on account of "weakness." Family history good; child fairly well nourished; had enteritis of four weeks' duration when one month old, and bronchitis lasting three weeks with two convulsions at the age of one year. Has always been "delicate" and nervous; cannot walk far, as she complains of pain in her knees. Teeth good; moderate "knock-knee"; height  $37\frac{1}{2}$  inches; weight  $32\frac{1}{2}$  pounds (fifteen months previously 32 pounds). No organic or constitutional disease was found. The only suspicious point was the almost stationary weight, which in an ordinary healthy child of her age should clearly have increased many pounds in the course of fifteen months. She was ordered Sanatogen, one teaspoonful twice daily, and at once began to put on weight at an average of half a pound weekly. The error of nutrition, in this instance of obscure origin, appears to have been effectually remedied by a simple dietetic treatment.

*Case VII.*—M. N., a gentleman, of middle age, who had suffered for eleven months from epithelioma of the soft palate. About the second week in September, 1904, he had reached an extreme stage of emaciation, and had taken for several weeks to his bed, from which he had before that time been carried downstairs in a chair. Sanatogen was ordered in teaspoonful doses twice daily in milk. A marked improvement in the general condition rapidly followed. The hollows in the cheeks and temples became much less visible, and after a time the patient actually walked downstairs, and interested himself in painting picture-frames and so on. More striking still was the fact that he several times asked for and ate a boiled egg, although he had taken nothing but "spoon" diet for months previously. In this case Sanatogen produced a distinctly favourable effect on the general nutrition and condition. The improvement was far more marked than happens in the occasional "turn for the better" met with in most cases of malignant disease, and lasted for many weeks.

Although I have had no experience personally of the use of Sanatogen in convalescence from enteric fever, a medical friend has found it invaluable under those circumstances. Anything that can help one to tide over the anxious period of typhoid convalescence will be sure of a warm welcome by medical men. For many years it was the invariable rule both in hospital and in private practice not to give any food beyond milk, cream, and beef-tea until the temperature had been normal for ten days. During that time of probation patients craved for food incessantly, and suffered much distress from restless nights and from the pangs of hunger. This rule was gradually relaxed; first coffee and then mashed bananas and cream were allowed, and the time of probation shortened. It is now admitted by many good authorities that solid food may be given in milk after the fourth day of normal temperature with absolute safety. The comfort of the patient is thereby much increased, and his convalescence shortened. In this and in the

other conditions above mentioned, Sanatogen deserves a careful trial by medical practitioners, as a readily assimilable form of semi-solid food. It is readily prepared, moreover, a point of some importance in the sickroom.

On the Continent, Professor Ewald (a) has spoken warmly of the value of Sanatogen in enteric fever. He administered that food to a patient on the fifth day after admission to hospital early in the third week of an attack of typhoid fever. As the result of experimental investigations he concluded that Sanatogen is valuable, on account of its ready absorbability, in all cases of physical weakness, "as well as in the acute stages of all those maladies which are accompanied by high rise of temperature and particularly in enteric fever." Dr. Eduard Rybiezka (b) advocates the use of the same preparation in convalescence from the malady in question.

*Case VIII.*—A lady, æt. 50, single, complaining of stiff joints and wasting. Her mother died of phthisis, also a brother. When young she had an attack of St. Vitus' dance, after falling downstairs. Between 20 and 25 she suffered from chronic cough, and was treated for incipient consumption. General health had been good ever since, and she had been of active habits, and took a great deal of outdoor exercise. Seven or eight years ago her hands began to get stiff and painful, and later the feet, elbows and knees were involved. The hands showed the typical deformities of advanced osteo-arthritis; the fingers were enlarged at the joints, and those of the right deflected outwards and clawed; large swellings, both bony and bursal, were present on the backs of hands and wrists. The right hand was worse, as the fingers were partly clawed into the palm and the wrist also partly locked. There were tender spots on the hands, but for the most part tenderness and pain were absent. The feet, elbows and knees were more or less involved; the elbows could not be straightened, and there was a great deal of "egg-shell" deposit about the knees, especially the right. There had recently been a considerable loss of weight, although the appetite remained good. A careful search failed to reveal tubercle in the lungs or elsewhere, and no disease of heart, kidneys, or other organs accounted for the loss of weight. This patient was treated by the super-heated air method, introduced and perfected by the late Mr. Tällerman. The joints soon gained in power of movement, and the joint swellings diminished rapidly in size. At the same time the general health improved greatly. Sanatogen was ordered at the outset in teaspoonful doses twice daily. The patient was first seen on October 11th, when she weighed 6st. 9lbs. Sanatogen was first given on the 14th in teaspoonful doses thrice daily, increased gradually to two teaspoonfuls. The weight began to increase at once, and on October 28th the weight was 6st. 11lbs.

This case shows the value of a readily absorbable food in the perverted nutrition of a general disease like osteo-arthritis. The great loss of weight is met with occasionally in cases of rheumatoid arthritis in which there is no gross organic disease. A well-known physician has recently published several cases of extreme wasting in

(a) *Zeitschrift für diätetische und physikalische Therapie*. Von Leyden. Article by Dr. C. A. Ewald.

(b) *Wiener klinische Wochenschrift*, 1900, Vol. ix.

connection with pulmonary osteo-arthopathy. In my experiences the joint changes in these cases are the essential feature, and the thoracic trouble an accidental complication of more or less severity. For some years past I have had a large experience of osteo-arthritis cases at the Tallerman Free Institute. Scores of chronic osteo-arthritis or rheumatoid conditions were seen; a fair number, perhaps 25 per cent. of them, showed marked wasting, but I can recall only two or three in which there was serious advanced disease of heart or lungs. At the same time slight valvular murmurs were common enough, as might be expected from the frequent history of rheumatic fever in osteo-arthritis cases.



(D. Walsh.)

RADIOGRAM OF HAND IN CHRONIC OSTEO-ARTHRITIS.

It may be of interest to insert here a radiogram which I have taken of the left hand of this patient. It shows in various joints—as about the phalanges and wrist—the typical light bony outgrowths near the articulations, with destruction of cartilages and partly of epiphyses well seen in the first and fourth metacarpo-phalangeal joints. These appearances differ markedly from the bone changes in chronic gout, where parts of the bones are cut out sharply as if by a gouge. The thumb is dislocated from the metacarpal bone and its metacarpo-phalangeal joint is disorganised. The styloid process of the ulna is hypertrophied (it is tender to pressure). The wrist bones generally are obscured by effused material. The figure is a good specimen of the condition of bone met with in rheumatoid or, as it is nowadays more commonly called, “osteo-” arthritis, while the typical fusiform thickening of the fingers in that disease is particularly well shown.

## Clinical Records.

### NORTH-EASTERN HOSPITAL FOR CHILDREN.

#### *A Case of Infantile General Paralysis of the Insane.*

By GEORGE CARPENTER, M.D.,

Editor of the *British Journal of Children's Diseases*, Late Physician to the Evelina Hospital for Sick Children; Senior Assistant Physician to the North-Eastern Hospital for Children.

ELIZABETH C., æt. 11 $\frac{1}{2}$  years, was admitted into the North-Eastern Hospital for Children in July, 1903. It was stated that she was in perfect health until April, 1902, when she was lost for a night, and ever since then had been “queer in the head.” She has gradually been getting worse mentally ever since, being obstinate and screaming on the slightest provocation. There has been occasional frontal headache; she has slept badly and taken her food badly; she has never had any fits or seizures; ten years ago she had measles. There is no family history of insanity. Several healthy children were born to the parents. Next a child was born dead, this was followed by a living child, then the patient, and lastly a boy of eight years, who is suffering from nerve deafness in both ears.

*State on Admission.*—She has an unusually thick covering of subcutaneous fat, and her skin is natural. Mentally she has two well-defined states. She lies awake most of the twenty-four hours, and talks incoherent nonsense to herself quite quietly and oblivious of her surroundings. Such remarks as “The goldfish are very happy,” “No, Bobby is all right,” and so on, can be heard by those standing by her cot. During this her face wears a placid, self-pleased expression which calls to mind the fatuous type of the general paralysis of the insane patient.

On being crossed by contradicting one of her statements, or by disturbing her physically, she bursts into an attack of loud screaming and weeping, which lasts for a few hours. She will usually answer simple questions, and is obedient to such demands as putting out the tongue until this sudden storm be evoked. She has hallucinations of pleasant objects, such as flags, ladders, and bowls of water, which are quite common. Auditory and olfactory hallucinations have not been noticed. She continually mocks other children's cries or street cries, and imitates them well. She does not know her mother.

Her arms and legs are moved well, the former better than the latter. She can walk, and there is some slight spasticity of the lower limbs. There is a flickering tremor of the lower facial muscles when smiling or talking. The tongue is protruded normally, and has an occasional tremor. There is a fine tremor of both hands, which is most marked on first gripping an object. The plantar reflexes show typical Babinski response on both sides. The elbow-jerks are active. The supinator-jerks are abnormally increased. The knee-jerks are very active and equal. There are no clonuses. So far as can be ascertained sensation is unimpaired. Her organs are normal. She cries frequently when the desire occurs for micturition or defæcation, but has deficient power of retention, so that both evacuations are passed involuntarily. Her feet are cold and red, and sometimes blue—she has pes cavus.

She has a long face and depressed bridge of the nose. The facial muscles are generally well



developed, and there is no local wasting. There are no radiating scars about the mouth. She has typical Hutchinson's teeth. Her pupils are equal. They do not react at all to light, and the accommodation cannot be tested. The fundus oculi was examined under an anæsthetic. The optic discs were pale, and there was a small patch of choroiditis in the left eye. Vision was very defective, being lost to all but light. There was no reaction to a threatening movement.

The case is of interest owing to the youth of the patient and from the undoubted corroborative evidences of congenital syphilis associated with that condition.

[Shown to the Society for the Study of Disease in Children, November 20th, 1903.]

### Transactions of Societies.

CLINICAL SOCIETY OF LONDON.  
MEETING HELD FRIDAY, OCTOBER 28TH.

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

#### CLINICAL EVENING.

DR. F. E. BATTEN showed a case of Acute Ataxia in a boy, æt. 3½, due to Encephalitis Cerebelli. Patient had measles in March, 1904. During convalescence he became unconscious, and remained so for a week. He then had convulsions and tremors, and on becoming conscious he could not sit up or speak. A month later he had marked inco-ordination of both legs and arms. There was no paralysis. The knee-jerks were well marked, and a tendency to ankle-clonus. He swallowed well, and spoke in a low, hesitating manner. Since then only slight improvement has occurred. He has complained of "pins and needles" in his limbs. His mother complains that since his illness his moral sense has become much perverted.

The PRESIDENT recalled a case he saw some twenty-five years before, which at the time he considered to be one of disseminated sclerosis, although Dr. Moxon, who also saw the case, did not think so. Now, the case seemed to him to be one of cerebellar encephalitis, almost exactly simulating the one shown. His case completely recovered in two or three years, although there was no diminution in the ataxy for eighteen months.

DR. BATTEN said that on account of Luciani's well-known experiment demonstrating the connection between the cerebellar lobe and the heterolateral cerebral cortex he was of opinion that the cerebral cortex in this case must have been also damaged, thus explaining the non-improvement. He was interested to hear of Dr. Taylor's case, as it would incline him to give a better prognosis in his own.

DR. E. D. MACNAMARA showed a case of Acute Ascending Paralysis; Tetracoccus found in the Spinal Fluid. The patient, æt. 30, a waiter, admitted under Dr. Murrell, August 3rd, 1904, with the history of commencement of loss of power in legs eleven days before, which, within three days, had culminated in absolute palsy. Three days before admission there was weakness of the arms, difficulty in swallowing, and double vision. There is a history of syphilis at twenty-four, which was actively treated. There was on admission total paralysis of the legs except of the right hallux, weakness of the arms, defective articulation and ocular movements, and both pupils were almost inactive to light. No reflexes were obtained in the lower limbs; the other reflexes were normal, as also the electrical reactions. There were no subjective sensory symptoms, nor other objective signs. After August 8th improvement commenced, and has continued. Speech, ocular movements, the pupil reaction, and the arm movements have been recovered. He can move his legs, and the knee-jerks are returning, but he cannot yet walk.

DR. FARQUHAR BUZZARD referred to the tetracoccus he had found in a case of Landy's paralysis last year; the organism was pathogenic to animals, as was shown by Dr. Eyre. The tetracoccus shown that night was not unlike the one he had found, but he could not express a positive opinion on such a slight examination. The different conditions described under Landy's paralysis fell into three groups: (1) The true Landy's paralysis, characterised by sudden general paralysis of all the muscles, though more of the large; a few of the cases get quite well. (2) A type of paralysis equally sudden and disabling, but having the distribution of a peripheral neuritis. (3) Acute ascending meningo-myelitis, marked sensory and sphincter trouble being present.

DR. F. E. BATTEN compared the present case to a toxic paralysis, such as a diphtheritic one. The fact of recovery was against its being due to organisms actually in the nervous system.

DR. MACNAMARA, in reply, pointed out that when Landy's paralysis recovers, it usually does so completely, as one would expect from an acute specific infection. Dr. Eyre was at present testing the pathogenicity of the cultures, but so far had obtained no positive result.

DR. J. H. BRYANT showed two cases, brother and sister, of the Peroneal Type of Family Amyotrophy. The girl, æt. 12, had whooping-cough at four, after which she could not walk properly, and she was treated for infantile paralysis of the legs by orthopædic apparatus. At 5½ she had scarlet fever, and measles at 6 and 8 years. In 1900 wasting of the hands was first noticed, the muscles of the thenar and hypothenar eminences, and the interossei in the upper limb, the small muscles of the feet, the peronei, tibialis anticus, and extensor longus hallucis in the lower limb. The boy, æt. 8, was first noticed to become weak after measles at 2½, his legs frequently gave way, and he could not lift his big toes. When first seen, in 1903, the paralysis of the extensor longus hallucis was the most marked. The paralysis has increased, and the feet are now in a position of talipes equino-varus. A paternal uncle is similarly suffering from weakness and wasting of the legs and hands. His wasting began at the age of three, and he is now bed-ridden.

MR. JACKSON CLARKE showed a case of Hard Fibroma of the Scapula and Spine, in a female, æt. 24. The left scapula was painful, elevated, and fixed by a rounded tumour situated at the middle of the vertebral border. An exploration in May, 1901, exposed a hard, white growth, which hardly bled at all. It filled the subscapular fossa, and was attached to the ribs. As much as possible of the growth was removed. Since this operation the tumour has slowly extended upwards along the spine, causing much pain.

MR. W. G. SPENCER expressed the opinion that the condition might be a spreading fibrous myositis, thus bringing it into line with myositis ossificans.

MR. JACKSON CLARKE was sure that the mass was of new formation, on account of the definite capsule present.

MR. H. A. J. FAIRBANK showed two cases of Sprengel's Shoulder. A girl, æt. 4, had right scapula situated at a higher level than the left; also placed nearer the middle line, as seen when the arms were hanging by the side. The angle of the scapula is rounded off. A band runs from the occiput to the vertebral border. The mobility of the scapula is diminished, as seen when the arms are held horizontally forward. There is no defect in the shoulder-joint or other asymmetry. A girl, æt. 12, has the left scapula at a higher level. The mobility is very much diminished, with muscular weakness, but there is no sign of a fibrous band or bony ridge. The right leg is wasted, apparently from infantile paralysis; the dorsal spine is curved to the left, the lumbar to the right; and the right side of the face is flattened. In neither case is there any family history of such a deformity.

MR. JACKSON CLARKE showed a skiagraph of a similar case. He considered that three factors were essential—spine, rib, and scapular deformity, there being a varying degree of each in a given case.

Mr. RUPERT BUCKNALL referred to similar cases of his own, and discussed the various theories explaining the deformity—such as malposition of the arm *in utero*, primary defects, &c. The ridge passing from the scapula to the spine indicated a defect in the mesoblast, which forms the muscle round the scapula.

Mr. FAIRBANK, in reply, said that, in his opinion, the condition was one of primary defect. In favour of this were the associated defects of the vertebræ and ribs. There was probably a gradation between Sprengel's cases and the cases described by Willett and Walsham, in which a bony mass joined the scapula to the spine. He considered the ridge in his case to be fibrous contraction of the muscle, secondary to the unusual position of the scapula.

Mr. JACKSON CLARKE showed a case of Unilateral Congenital Dislocation of the Hip, reduced by the method of Lorenz. The girl, æt. 7, had a typical displacement at the right hip, which was reduced in August, 1903, as confirmed by a skiagraph. The abducted position was maintained for a year. The child is now walking about without apparatus, with the head of the femur in position. The treatment is not yet concluded.

Mr. NOBLE SMITH showed a case of Unilateral Congenital Dislocation of the Left Hip. A girl, æt. 6½ years, with the above was operated upon by the Paci-Lorenz method in January, 1894. The limb was maintained abducted for six months. The joint is now firm and movable, and the position of the femur is shown in a skiagraph. He also showed a case of Double Congenital Dislocation of the Hip. A girl, now æt. 7½, was operated on by the Paci-Lorenz method in January, 1903, and the abducted position maintained for six months. The joints are now firm and in a normal position, as shown by a skiagraph. The child continues to improve in gait.

Mr. TUBBY asked what evidence there was that the head of the femur was in the acetabulum. He knew of none except by operation. It was well known that a skiagraph of an anterior dislocation, taken at a certain angle, would portray an apparently perfect joint. Many cases reduced by Lorenz's method could be shown to be merely an anterior dislocation instead of a posterior.

Mr. JACKSON CLARKE knew of no such evidence, and even thought that an open operation often failed to decide the point. Actual demonstration of the reduction could only be obtained by watching Lorenz operate. After all, the important point was that whether a true reduction occurred or not perfect function was restored, although some stiffness might follow in the most successful cases.

Mr. NOBLE SMITH, by means of a model, gave a demonstration of the movements involved in mechanism of reduction. He agreed with Mr. Clarke in his remarks on the difference between performing the operation before seeing Lorenz do it, and after.

Mr. A. H. TUBBY showed a case of Ulceration of the Tongue, with Destruction of the Soft Palate, of Uncertain Origin. The affection of the tongue commenced with a hard lump, first noticed in January, 1904. There had been previous deafness on both sides for six months. There is now a rapidly spreading, large, ragged ulcer of the tongue, destruction of the soft palate has occurred, and there is ulceration of the naso-pharynx. There is no history of syphilis, and anti-syphilitic treatment has failed. The microscopic examination yielded negative results.

Mr. CHARTERS SYMONDS was of opinion that the man was tuberculous.

Mr. TUBBY discussed the diagnosis between congenital syphilis, tubercle, chronic glanders, and actinomycosis.

Mr. W. G. SPENCER showed a case two years after Excision of the Sac of a Spina Bifida (Meningo-myelocoele).—A boy, now æt. 2½, was operated upon when six months old. The cauda equina and nerves were dissected out and laid in the groove, which was closed by two rows of sutures. A firm scar now covers the

groove, the legs are used well, and there is no hydrocephalus.

Dr. NEWTON PITT showed a case of von Recklinghausen's Disease. A female, æt. 49, had at birth a tumour to the left of the sternum, and later numerous painless subcutaneous nodules were noticed. New tumours have appeared from time to time, many within the last five years, which at first were firm and prominent, and then, as they increase in size, they become softer. In 1877 Mr. Golding Bird removed a large unencapsuled tumour from the left calf; the tumour on the left chest then formed a pendulous pigmented mass five inches in length. It was removed in 1895, and weighed 3½ lbs. Also in 1877 a raised, pigmented, hairy mole with a molluscum tumour, 4 by 1½ inches, was removed from the right cheek. The patient has now a diffuse fibroid swelling of the left calf, with irregular scarring resulting from the operation; a recurrence of molluscum fibrosus tumours in the right cheek; innumerable raised tumours, from ¼ to ½ of an inch across, scattered over the limbs and face, and, to a less extent, on the body, the skin over them being not generally pigmented. There are no obvious signs of involvement of the large nerve-trunks.

Mr. O. L. ADDISON showed for Mr. A. E. BARKER a case of Lymphangiectasis with escape of Chyle. A man, æt. 20, has a cystic swelling of varying dimensions above Poupart's ligament, and enlargement of the thigh. The disease has been noted since the age of seven years. Chyle escapes from an opening in Scarpa's triangle. If the escape is temporarily prevented by a pad an enlargement occurs in the iliac region. Then the chyle, when allowed, escapes in a stream, and the patient feels relief from tension.

Mr. O. L. ADDISON, replying to questions put by Dr. French, said that the fluid was chylous, and not lymphatic, and so the obstruction must be of the thoracic duct. He drew attention to the fact that the fluid escaped under pressure, spurting to three or four inches, whereas in all the cases previously reported the fluid had only trickled. There had been no suggestion as to the cause of the condition.

The following cases were shown by Mr. CHARTERS SYMONDS:—(1) Simultaneous Ligature of the Common Carotid and Subclavian Arteries for Aortic Aneurysm.

Mr. W. C. SPENCER referred to cases operated on by Mr. Christopher Heath. In those he had seen the results were not good.

Mr. RUPERT BUCKNALL had seen several of Mr. Heath's cases in which good results were obtained. He had himself operated on one case which was rapidly growing. After ligature first of the left common carotid, and then of the left subclavian artery, hardening took place. The man returned to work for two years, then died of phthisis. At the autopsy the aneurysm was found to be healed. He thought that the line of treatment was of great benefit and worthy of wider recognition.

(2) A case of Bony Union after Fracture of the Patella without Wiring.

(3) A case of Popliteal Aneurysm after Ligature of the Superficial Femoral artery.

#### NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LIVERPOOL, FRIDAY, OCTOBER 21ST.

Dr. W. J. SINCLAIR, President, in the Chair.

Dr. R. FAVELL (Sheffield) showed a dermoid cyst of the ovary and an ectopic gestation, interesting for the reason that each had had the appendix vermiformis adherent to it. He referred to Howard Kelly's paper on the subject, in which 115 cases are tabulated.

Specimens were also shown by Drs. W. E. FOTHERGILL and MURRAY CAIRNS, and Dr. LLOYD ROBERTS exhibited an improved needle-holder. Dr. E. EMRYS ROBERTS gave a lantern demonstration of the first stage of implantation of the ovum of the guinea-pig.

Dr. ARNOLD LEA (Manchester) detailed a case of



## RUPTURE OF THE UTERUS,

which took place at the seventh month of the fourth pregnancy of a woman, æt. 24. She was admitted to the Maternity Hospital for sudden profuse bleeding due to placenta prævia. Twenty hours after admission a de Ribes bag was inserted into the cervix. Five hours later the pulse had gone up to 124. Dr. Lea arrived at the hospital shortly afterwards and found the patient's condition was good. The bag was removed, and under chloroform bipolar version was performed, the hand not being introduced into the uterus, and a macerated seven months fetus was readily extracted. The patient's pulse then became very rapid, and her skin pallid. The placenta was easily expressed, and the uterus appeared to contract well. A deep tear of the left side of the cervix was sutured. The pulse remained 130 to 134, but the patient was quite comfortable when placed in bed. A quarter of a grain of morphia was given, and also a rectal injection of saline solution with an ounce of brandy. Half an hour later she became suddenly blanched, her pulse failed completely, and she died in five minutes, obviously from internal hæmorrhage. There had been no bleeding *per vaginam*, and the uterus appeared well contracted. An autopsy was made twelve hours after death. The peritoneal cavity contained nearly a pint of blood, which had escaped through a rent in the posterior layer of the left broad ligament. There was a lateral tear three inches in length in the lower uterine segment; this had led to the formation of a huge hæmatoma between the layers of the left broad ligament, and this had ruptured, through a linear rent, into the peritoneal cavity. The uterine muscle was pale, soft and apparently degenerated, and the placental site where the tear occurred was thinned. Regarding the cause of rupture, Dr. Lea said there was a great probability that the patient had had syphilis, her previous children being born prematurely, either dead or dying shortly after birth. The rupture occurred at the placental site, there was no evidence of a retraction ring, the membranes being ruptured shortly before delivery was effected. He thought the rupture probably occurred spontaneously whilst the de Ribes bag occupied the lower segment of the uterus as shown by the rise of pulse to 126. Extraction probably made the tear complete. The three factors in the causation were thus, degeneration of muscle, probably syphilitic; low situation of placenta; aggravation of rupture by version and extraction. The tear was at first incomplete, leading to the formation of a hæmatoma of the broad ligament. Sudden rupture of the posterior layer of the broad ligament permitted free bleeding into the cœlum, and death followed. Discussing the symptoms of this form of rupture, Dr. Lea remarked they were often obscure. In his case there was an absence of all pain, of external bleeding, whilst the uterus appeared by abdominal examination to be firmly contracted. The fetus lay high up, but not more so than normal. In short, the sole characteristic was increase of pulse-rate, and even this, owing to the previous hæmorrhage, had not had sufficient stress laid upon it. Had the tear been recognised immediately after delivery, Dr. Lea said he considered the proper treatment would have been to pack with gauze.

Dr. LLOYD ROBERTS (Manchester) in commenting on the case, thought that everything possible had been done.

Dr. WALTER (Manchester) thought the case illustrated the risk attendant on the use of de Ribes' bag. He had known of two instances in which the bag had disappeared entirely within the uterus. It was important, when employing it, to be quite certain as to the quantity of water pumped into it.

Dr. W. K. WALLS (Manchester) said his experience embraced two similar cases, and he considered that the rupture was due to the delivery and not to the bag.

The PRESIDENT thought it possible that the tear might have occurred during the introduction of the bag.

Dr. LEA briefly replied.

Dr. W. K. WALLS reported a case in which a mass of multiple fibro-myomata of the uterus occupied a large ventral hernia. The patient was married, æt. 44, and the menopause occurred at 35; no pregnancies. History of three operations five years previously, presumably laparotomy. The large ventral hernia contained a solid mass and also fluid; the skin was ulcerated in places; behind the hernia a solid mass extended from pubes to umbilicus. The cervix uteri was drawn up out of reach. At the operation the sac contained about a dozen fibroids varying in size from a hen's egg to an orange. Supra-vaginal hysterectomy was performed and a good recovery ensued. The mass of tumours (shown) weighed 11 lbs.

The case was discussed by Drs. Lloyd Roberts and T. B. Grimsdale, and Dr. WALLS replied.

## LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD OCTOBER 20TH, 1904.

The President, Dr. JAMES BARR, in the Chair.

MR. CHARLES G. LEE read a short paper on the SIMPLE EXTRACTION OF CATARACT BY TEALE'S METHOD.

He briefly referred to the various incisions that from time to time had been adopted, and said that all of these, being placed either behind or at the circumference of the cornea, rendered it almost imperative to excise a portion of the iris. If, therefore, it were deemed necessary to perform an iridectomy as part of the operation, then the better plan is to do it some days or weeks before the extraction, as this method, although it involves two sittings, made less demand upon the patient's self-control, and enables the operator to see clearly each step of the operation, since no blood collects in the anterior chamber, as happens when the iridectomy and the extraction are both done at the same time. The chief objection to this procedure lay in the two operations, and consequently the danger from sepsis was doubled. Having in his private practice last year lost an eye from suppuraction of the cornea, after a preliminary iridectomy, Mr. Lee determined to try if the iridectomy might not be dispensed with as an essential part of the operation. He had himself frequently performed simple extraction, but owing to the incision being placed at the periphery of the cornea, prolapse of the iris had too often occurred. Some twenty years ago he had seen Mr. Pridgin Teale extract cataracts without an iridectomy, by means of an incision wholly in the corneal structure, and almost midway between the centre of the pupil and the circumference of the cornea, so he determined to try this method. Two characteristic features of the operation were insisted upon—the knife employed (Hartley's) and the site of the section. Details of the first eight cases which Mr. Lee had operated upon by this method were given, from which it appeared one patient obtained visual acuity of 6-6, three obtained 6-9, and none less than 6-18. In no case was any difficulty experienced in carrying out the *technique* of the operation. Since these results were obtained by an operator to whom the method was novel, it was submitted that it was well deserving of a trial by all who wished to advance the art of ophthalmic surgery.

Dr. K. A. GROSSMANN said he had performed simple extraction for many years and was well satisfied with the results obtained; but emphasised the importance of carefully selecting the cases suitable for it. He used a knife with a very narrow blade, as he considered the triangular-shaped knife too broad, for it hampered the freedom and delicacy of movement necessary in so delicate an operation.

Mr. GEORGE E. WALKER described an operation which he had performed for upwards of twenty years, which aimed at the same result as that mentioned by Mr. Lee, and which he considered easier of performance. The puncture and counter-puncture are made in the sclerotic, and by a series of sawing movements the incision finishes at a point midway between the centre of the pupil and the top of the cornea. In this operation

prolapse of the iris, if it occur, is seldom considerable, and, as a rule, easily reduced.

Mr. CHARLES H. B. SHEARS said that many of the most experienced operators, both in this country, on the Continent, and in America, still performed the combined operation, and for his own part he employed it as the routine treatment, reserving the simple method for cases with hard, brown lenses.

Mr. R. J. HAMILTON used a narrow-bladed knife and made the incision within the sclero-corneal margin. He considered that operators had the best results who could employ either the simple or the combined method.

Mr. RICHARD WILLIAMS said it did not matter a great deal which method of operating was adopted; but it was of great importance that the surgeon should be an expert in whatever method he might select. Personally, he performed the combined method of operating as he considered it the safer and the easier of the two.

Dr. W. MURRAY CAIRNS read a paper on the PRACTICE OF ASEPSIS IN OBSTETRICS, in which he made a strong plea for the more careful conduction of labour. At the outset he differentiated between aseptic obstetrics and *asepsis in obstetrics*. Precautions to be taken for the maintenance of the status asepticus before, during, and after labour, on the part of the surgeon, nurse and patient, were fully set forth. The advantages and disadvantages attendant upon the use of aseptic rubber gloves in obstetrical work were fully discussed, and the hope was expressed that a material more suitable for intra-uterine manipulation than rubber has hitherto proved might be discovered. A form of obstetric bag adapted to modern aseptic requirements was described. Asepsis in relation to (a) physiological, and (b) pathological labour was reviewed. In regard to the former, meddling manipulation was very strongly condemned; "hands off" was declared to be the keynote of aseptic labour. The use of lubricants was in general to be deprecated; if used at all, lubricants should, it was contended, be sterilised. The conditions under which the douche should and should not be used were laid down. Douching, ante- and post-partum, in strictly normal cases, was declared unnecessary. In all infective conditions, douching, both ante- and post-partum, was considered necessary, and it was recommended that it should always in such cases be antiseptic and administered by the surgeon. The advantage of asepsis over antiseptics was shown to be of considerable importance in the case of individuals who showed idiosyncrasy towards antiseptics. A strong warning was given lest the preliminary canons of cleanliness be overlooked—soap, water, nail-brush, and patience.

Dr. E. T. DAVIES, Dr. Llewellyn A. Morgan, Dr. Alexander Stokes, Dr. J. H. Finegan, Dr. T. B. Grimdale, Dr. J. H. Willett, and Dr. Nalini H. Blair took part in the discussion.

#### THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

At a meeting of the Society, held on October 21st, at 11 Chandos Street, W., Dr. FLETCHER BEACH in the Chair, four new members were elected and twenty-one were nominated for ballot at the next meeting.

Dr. C. O. HAWTHORNE showed a case of Hypertrophy of the Right Lower Limb. The patient was shown to the Society in 1902 ("Transactions," II., p. 114). The patches previously described as hæmorrhagic on the front of the leg ulcerated some twelve months ago, and have never healed. The question to be now decided was the advisability of amputation.

Mr. A. EDMUNDS advocated a prolonged trial of hospital treatment before recourse to amputation.

Dr. O. F. GRUNBAUM showed a Microcephalic Infant with Tropic Edema of the Feet, and a sister and brother with Congenital Hereditary Tropic Edema. The maternal grandmother of the two latter was also affected. The girl, æt. 7, showed swelling of both lower

limbs from the knee downwards, with harsh, thick skin of normal colour. The œdema was hard, but pitted on continued pressure. The size of the legs did not diminish on raising the feet, but could be temporarily decreased by applying a rubber bandage. The child had not complained of pain. The brother, æt. 5 months, showed a similar condition, and the hypertrophy of the skin was more easily demonstrated. In both cases the œdema was symmetrical. The cases were discussed by the Chairman, Mr. A. H. Tubby, Dr. F. Parkes Weber, Dr. J. Porter Parkinson, Mr. G. Pernet, and Dr. C. O. Hawthorne, and Dr. GRUNBAUM replied.

Dr. L. GUTHRIE showed (by permission of Dr. G. Ogilvie) a case of Cerebral Diplegic Athetosis in a boy, æt. 6, who had convulsions on the sixth day of an attack of measles last February. He was unconscious for seven weeks, speechless, paralysed on the right side, and lost sphincter control. At present he was regaining speech, did not seem mentally deficient, and had some sphincter control. There was no hemiplegia. He could not sit or stand, and had typical athetoid movements of the trunk and extremities.

Dr. GUTHRIE also showed a case of Polio-encephalitis (Cerebellar), occurring during measles last February. Intelligence was normal; speech, monotonous and scanning; slight tremor and ataxia of the upper limbs, and marked inco-ordination of the lower ones were present. The gait was typical of cerebellar disease. In commenting on the cases, Dr. Guthrie said that both were probably instances of polio-encephalitis during measles. In the boy the cortical and sub-cortical centre were chiefly involved, and in the girl mainly the cerebellum.

Dr. R. HUTCHISON showed a case of Habit Spasm in a boy, æt. 10. The spasm chiefly affected the muscles of the right side of the neck, had been present for two years, and had resisted all treatment.

Mr. Donald Armour, Dr. G. A. Sutherland, Dr. Porter Parkinson, Dr. C. H. Milburn (of Hull), and the Chairman discussed the case.

Dr. HUTCHISON also showed a case of Bromide Rash in a child, æt. 2. The spots were of the fleshy sort usually met with in young children.

Drs. Poynton and Parkes Weber made some remarks.

Mr. ARTHUR EDMUNDS showed a case of Infantile Paralysis with permanent involvement of the abdominal muscles. The attack had been very generalised and very severe. Now there was marked ballooning of the abdominal wall, in the area corresponding roughly with the distribution of the eighth and ninth dorsal nerves.

Dr. SUTHERLAND pointed out that without the history and the other evidence of infantile paralysis the case might have been mistaken for one of congenital absence of muscle in the abdominal wall, the cause of which was not well understood.

Mr. N. BISHOP HARMAN showed a case of Congenital Bilateral and Symmetrical Dislocation of the Crystalline Lenses. He suggested opening the anterior chamber and removing the capsule of the lens by seizing it with Couper's capsule-forceps.

Mr. SYDNEY STEPHENSON showed a case of Cerebral Degeneration with fundus changes in a boy, æt. 7.

Mr. P. LOCKHART MUMMERY showed a boy, æt. 8, with a dermoid cyst of the auricle in an unusual situation, rather too high up, in his opinion, to be due to a persistent portion of the intermaxillary cleft.

Dr. EDMUND CAUTLEY showed a child, æt. 3, with Congenital Heart Disease, Paralysis of the Left Superior Rectus, and an Abnormal Artery on the back of the Left Forearm. He thought the murmur due to a direct communication between the aorta and pulmonary artery, or to a patent ductus arteriosus.

Dr. CAUTLEY also showed a child, æt. 21 months, with a microcephalic head, imbecility, a moderate degree of spasticity, and irregular movements of the limbs and trunk. He regarded it as due to a combination of microcephaly and cerebral changes.

The Chairman and Dr. Parkinson commented on the case.

A photograph of Trichotillomania was shown by Mr. GEORGE PERNET, and one of extensive Herpes Zoster of the Left Arm by Dr. G. CARPENTER.

Mr. R. C. CLEMENT LUCAS read a paper "On an Ill-Developed Upper Lateral Incisor Tooth as a Fore-runner of Hare-lip or Cleft Palate."

Dr. E. GILFORD read a paper on "Two Cases of Congenital Diaphragmatic Hernia." In each case the child was *et.* 4 months, and had had no abdominal symptoms. One was moribund on admission to hospital, and was supposed to be suffering from sinus thrombosis. The other was admitted for bronchitis and paroxysmal dyspnoea. After death the third part of the duodenum, the whole of the small intestine, and the ascending colon had passed through an opening at the posterior part of the right half of the diaphragm. In neither case was there a sac. The cases were remarkable in their similarity to each other, and their dissimilarity from other recorded instances.

The meeting then adjourned.

### THE CHILDHOOD SOCIETY.

MEETING HELD OCTOBER 20TH, 1904.

SIR T. LAUDER BRUNTON, Bart., M.D., in the Chair.

#### A DISCUSSION ON

##### PHYSICAL DETERIORATION

was opened by Mr. E. W. BRABROOK, C.B., who said there was no evidence based on statistics to show deterioration. The best evidence could be gathered from large friendly societies, such as the Manchester Unity, with its million of members. True, sickness was increasing, but length of life also. Then the healthy and sensible were less inclined to marriage, so the recruiting of population came largely from the physically inferior.

Mrs. A. WATT SMYTH spoke strongly on the subject of milk depôts, urging that mischief done in infancy could never be undone, and advocating also the teaching of simple cooking to both boys and girls, and the selling of these meals at a minimum charge to the children as in Germany.

Dr. ROBT. HUTCHISON differed from Mrs. Watt Smyth concerning "irreparable mischief," as puny children sent to industrial schools often developed into sturdy ones. The milk depôts were becoming more necessary as the art and habit of natural feeding was, for reasons he could not then enter into, becoming less common. Food among the poor was not always scanty, but ill-chosen, and quantities of white bread, jam, and tea chosen instead of wholesome things such as porridge and milk. Even in High schools the interval, often 8 to 1.30, was too long, and rich children were often left to nurses. A type of man suited to congested city life was forming; the large frame was dying out and a small, wiry type coming in. Everything depended on food, a well-fed child could stand cold and want of clothes.

Dr. SHUTTLEWORTH thought deterioration was not more common, but more noticed. Society was becoming alive to defects, but still averse to providing funds for the necessary investigations and prevention.

Dr. WARNER was of opinion that the modern system of building high blocks of houses and excluding the sun from the children's only playground—the street—would eventually be a powerful factor in deterioration. Moreover, modern mothers should be taught to buy nourishing food and how to cook it, as education as well as light and air were essential to good growth. He would suggest schools being built out of the town and cheap cars be run to take the children to school.

The CHAIRMAN concluded that it was evident that much remained to be done in the way of steady investigation of facts and circulating, by demonstration and literature, the right rules which govern healthy living.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, October 30th, 1904.

### TAPPING THE BLADDER.

TAPPING the bladder consists in inserting, above the pubis, a trocar or needle of an aspirator into the bladder to evacuate the contents. Tapping through the perinæum or the rectum employed by the old surgeons has been completely abandoned to-day. This little operation, says M. Tuffier, is easily performed, and presents in itself no danger. It is possible to wound an important organ or the peritoneum, but by taking a little precaution the patient will run no risk. The bladder is in direct contact with the abdomen, and is situated immediately above the symphysis pubis, and when it contains about ten ounces of liquid the anterior peritoneal cul-de-sac is at a distance of from half to one inch from the symphysis, a distance sufficient to allow the bladder to be reached without injury to the neighbouring parts. However, it may happen that the peritoneum from adherence with the symphysis may be wounded; this accident, thanks to antiseptics and asepsis, is of little importance.

The trocar should be inserted in the median line, as it is here that the peritoneum is situated the highest up; but before operating, the surgeon must assure himself by palpation and percussion that the bladder is really distended. The instrument used can be a straight trocar, or the needle of a Dieulafoy or Potain aspirator. As in every operation, of no matter what kind, the teguments should be shaved and washed with a sublimate solution and alcohol.

The patient lies on his back, the legs stretched out, the operator seizes the needle firmly in his right hand, and, fixing with the index of the left hand the spot of insertion (half an inch above the edge of the pubis), he pushes it boldly in. The sensation of resistance conquered, the impression that the extremity of the needle is free, indicates that the bladder has been reached. If the bladder is greatly distended, it is preferable not to empty it completely, for fear of intravesical hæmorrhage; it is better to renew the operation a few hours afterwards if necessary.

The operation thus performed causes but very little suffering, and is inoffensive. It can be repeated as frequently as may be judged necessary, for it is less grave than catheterism imprudently executed. Before withdrawing the needle care should be taken to allow air to penetrate into the aspirator so as to avoid the possible infiltration of a few drops of urine into the tissue. Tapping the bladder is indicated in every case of acute urinary retention, where it is impossible to evacuate the reservoir by careful catheterism, as, for instance, in hypertrophy of the prostate; rupture of the urethra, fracture of the pelvis, and in certain forms of stricture. It sometimes occurs that in stricture it is impossible to pass the smallest catheter; if retention of urine exists, tapping should be immediately resorted to, and this operation is not only useful to the patient, but produces decongestion of the region of the urethra, permitting the easy passage of a bougie.

In acute retention from hypertrophy of the prostate, puncture of the bladder is very frequently indicated, and is absolutely necessary in the case of a patient who has been subjected to vain attempts at passing a catheter, and where a false direction may be feared. In old persons, where the urine is more or less infected, the hypogastric incision should be preferred to the puncture.

MIGRAINE IN CHILDREN.  
Antypyrene, xxx grains.  
Caffeine, x grains.  
Syrup, vi drachms.  
Water, ad. ii ounces.

A teaspoonful at the moment of the attack.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 29th, 1904.

#### ACETOPYRINE.

THIS new antipyretic is said (*Deutsch. med. Zeitung*, '77, '04) to be an excellent agent for reducing temperature, also that it has no injurious effect on the heart. In toxic doses it is a respiratory poison; in medicinal doses respiration is rendered more shallow. Being excreted through the kidneys it increases diuresis; it reduces the size of the spleen. The pancreatic secretion is enormously increased, and this would lead one to conjecture that it would be useful in the pancreatic form of diabetes. The perspiratory stage comes on late and lasts only a short time. If other observers confirm the conclusions arrived at by Dr. Zwintz, to whom we are indebted for the exposition of the properties of acetopyrine, there will be hope that in it we shall find a useful addition to our armamentarium.

#### A SUBSTITUTE FOR IODOFORM—ALMATEIN.

Almatein is the name given by the makers to a new combination of hæmatoxylin with formaldehyde, and intended as a substitute for iodoform, for this useful but most objectionably-smelling drug is still in frequent use. A considerable number of cases are recorded by Bertini in which it was used in septic wounds, phlegmons and the like, and always with marked success. The powder is odourless, and that, no doubt, will commend it to all users of iodoform on other people, and it is also free from any toxic properties. The makers are Lepetit Dollfuss and Gausser.

#### THE ISOLATED UTERUS.

In the *Archiv. f. Gynäkol.*, 73, '04, is an article by E. N. Kurdinowsky describing the uterus after removal from the body. The isolated uterus, the writer says, can be seen on the second, and even on the third day, to make very energetic contractions, and to form a curve. In one case the uterus lived forty-nine hours forty minutes. The observer succeeded in reproducing the act of birth in all its individual parts, from the commencement to the end. The contractions caused the separation of the ovum. The cornu thrust its contents into the cavity of the uterus. Then energetic contraction of the ligamentum latum began; these forced the ovum into the vagina. The investigation showed that the birth act could be carried out in complete independence of the cerebro-spinal system. Cold and warmth acted equally energetically on the uterus, and, generally speaking, it was these oscillations that supplied the stimulus to contraction. The isolated uterus was but little susceptible to electric stimulation. These observations bring prominently forward the great probability of a local innervation.

Hydrastin did not act on the vessels of the isolated uterus. Ergot acted peripherally on the uterus quite independently of any contracting effect on its vessels. Narcotic poisons affected the uterus but very little. Adrenalin strengthened the contractile activity of the uterus more than any agent looked upon as specific. This, along with its great power of contracting vessels, ought to lead to further careful clinical study of the remarkable example of organo-therapeutics.]

At the Congress of Scientists and Physicians, Herr Magnus Hirschfeld showed some cases of

TRANSITION BETWEEN THE MALE AND FEMALE, one of which excited a good deal of interest. The case was that of a woman born in East Prussia in 1862, who really was a man. Believed to be a female at her birth, she was brought up as one; at sixteen her voice changed, and at twenty her beard grew, so that daily shaving was necessary. Her inclinations were decidedly male; she would rather be a soldier than anything. Towards men she had such a strong feeling of repulsion that she refused four offers of marriage which gentlemen who had been attracted by the stately and resolute "dame" made to her. On the other hand, she repeatedly fell in love with members of the female sex. When she was examined, it was found that the reproductive glands were male. Then it was proposed that she should dress and behave as a man, but she declined, as she could not face the sensation that such a complete *volte face* would be sure to cause among her acquaintances.

Dr. V. Kruedener relates a case of  
HERPES ZOSTER IN THE REGION OF THE FIRST LEFT  
BRANCH OF THE TRIGEMINUS.

The patient was a man, æt. 50, who, after a severe chill, had marked redness of the forehead, and the skin became covered with vesicles, which in part were black in colour owing to a partial gangrene of the parts. The following terminal branches were affected over the whole region supplied by them: the lachrymal, supra-orbital, frontal, supratrochlear, infratrochlear and the nasociliary. A few vesicles were on the bridge of the nose, and the redness extended about one centimetre over the middle line, this being in agreement with the observations of Zander on the subject, to the effect that the region supplied by the trigeminus of one side passes just over the middle line to the opposite side. The nature of the disease had been made a little more clear of late. If the Gasserian ganglion was to be viewed as a spinal ganglion, resemblance between the diseases of both would be shown. Treatment had to be directed to the nerve; aspermin and sweating brought about an improvement in a few days.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 30th, 1904.

#### THE DIAGNOSIS OF TUBERCULOSIS.

At the Breslau meeting, Kraemer criticised the latest opinions of Naegle on the frequent changes of tubercle in the lung. The chalky nature of tubercle, he affirmed, was not yet proved, neither could we be assured that it was infectious, nor on the increase if statistics are to be believed.

In the diagnosis of tuberculosis in the lung, Freymuth recommended the administration of Koch's old tuberculin in the form of pill covered with keratin. This acted as promptly in exciting the febrile reaction as when injected subcutaneously. Different intensities of fever were measures of the progress of the disease, and as the bacilli did not appear in the sputa at the commencement of the disease, a few pills of tuberculin were of great value in the diagnosis of obscure cases. One point he wished to impress on his hearers was that when given internally the fever was not as intense in the very early stages as in subcutaneous administration, which may be proved by giving a stomachic dose and subsequently a very small subcutaneous injection, the system seeming more sensitive after an internal dose.

Nourney said he was a great believer in tuberculin treatment, after several years' experience with small doses not exceeding 0.0001 gramme. This was equally efficacious in the cure of lupus.

Holdheim recorded the history of two cases under treatment with tuberculin for two years with ultimate cure. Other fifteen cases were greatly improved by its application.

Pauli regretted the general disuse of tuberculin in the treatment and early diagnosis of tubercle in the lung. Tuberculin was of no value as a diagnostic in patients under twenty-two years of age.

Schneider would not discuss the propriety of the use or disuse of tuberculin, but urged enthusiasts to be guided by the pulse frequency in their prognosis of cases. If the pulse ranges above 100 per minute the case is a very grave one, and may become aggravated by many forms of treatment.

#### HYPERÆMIC TREATMENT OF PHTHISIS.

Wassermann gave a description of his theory of the passive hyperæmic treatment in phthisis. He accepts the dictum that tuberculosis is the result of anæmia of the lung, and contends that gymnastics are the rational method of dealing with phthisis. With the same object in view he causes a narrow opening for inspiration, leaving the mouth free and open for exploration. With an instrument of this kind the breathing is laboured, while the force produced causes passive hyperæmia in the lung, which ultimately produces a healthy condition of the organ. In all his experiments with this treatment he has never met with hæmoptosis.

#### BACTERIAL ACTION OF SERUM IN TYPHOID.

Stern gave many examples of bacterial action in blood serums, particularly the typhoid bacilli, when treated in the test tube. He applied fresh blood of a typhoid case to a bouillon culture to prove that the blood serum of typhus had no more action than the blood serum of a healthy man. The interest of this experiment lay in the newly drawn blood, which he attempted to prove was less active than the bacilli after cultivation. He thought this was the cause of many of our failures in the production of immunity by different sera, and was of the opinion that this destroyed the theory of an intermediary body or immune principle that it was necessary for the protection of typhoid.

#### RECURRENT TYPHOID.

Hodlemoser gave his experience of an epidemic of typhoid recurrens which raged for a long time in Herzegovina. He tried on several occasions to cultivate a serum, in the hope of producing immunity, but found it difficult owing to the recurrent spirillum disappearing during the interval, and at the same time affirmed that the Obermeier spirillum was very difficult to cultivate.

## The Operating Theatres.

### KING'S COLLEGE HOSPITAL.

COMBINED SUPRAPUBIC LITHOTOMY AND PROSTATECTOMY.—Mr. CARLESS operated on a man, æt. 66, who had been sent into the hospital complaining of pain before, during and after micturition, and associated irritability of the rectum, the bowel emptying itself every time micturition was attempted. These symptoms had gradually increased during the last four months, and the pain now continued for about twenty minutes in all. It was located deeply in the perinæum, and did not extend to the tip of the penis. There had never been hæmaturia, but the urine contained some

mucopus, together with phosphatic and oxalate crystals. A certain amount of mucus was evacuated by the bowel. On palpation nothing abnormal could be felt through the abdomen, but on rectal examination the prostate was found to be considerably enlarged. On the introduction of a sound, the presence of one or more vesical calculi was determined. The patient was anæsthetised, his pelvis raised and the bladder washed out with boric acid lotion, about half a pint being left in. The usual suprapubic incision was then made, and the bladder exposed. A silk sling was passed through the vesical wall on either side of the middle line, and the viscus incised from above downwards. The mucous membrane was secured on either side with Spencer Wells' forceps and held well up; it was found to be thick and congested. On the introduction of the finger the prostate was found to be large and projecting into the cavity, and in the pouch behind it a whole colony of stones was discovered; they were removed by forceps and fingers, and were found to be nineteen in number. The mucous membrane at the back of the prostate was next incised and the enlarged prostate enucleated without difficulty, coming away in two portions, the urethra apparently being left behind; this was facilitated by pressing the prostate upwards with the fingers of the left hand in the rectum. A sterilised india-rubber glove had been worn thus far on the left hand; it was then removed, so that the left hand, after purification, could be used in the remainder of the operation. The incision in the bladder was closed around a tube passed into it by catgut stitches which missed the mucous membrane. The upper part of the space between the recti muscles was closed by similar sutures, and the upper part of the skin round approximated. The cavity then left was packed with gauze, and an ordinary dressing applied. Mr. Carless pointed out that the absence of the typical symptoms of stone in this case was due to the calculi being located behind the prostate, so that they were not brought in contact with the internal meatus during micturition. They were of a light brown colour and most of them quite smooth, though many had blunt projections on one or other side. One of them was long and narrow-shaped, somewhat like a banana. They were probably composed of uric acid. The prostatic enlargement, he said, was of the ordinary senile character, and the masses removed showed well that they consisted of multiple rounded bodies, probably adenomata united together to form one mass, which, however, was easily broken into two along the anterior and posterior commissures. Mr. Carless' firm opinion was that most cases of prostatectomy consisted of an intra-glandular enucleation of adenomatous masses. In this particular instance, he remarked, the growth was apparently peeled off the urethra, which could be felt in the cavity left behind; it was probably a matter of very little importance whether the urethra was retained or not during the process of cicatrisation that followed. The mucous membrane of the bladder was approximated to that of the membranous urethra, and the cavity was always sufficiently large to obviate any likelihood of the development of stricture.

### ROYAL FREE HOSPITAL.

ENUCLEATION OF THE EYE FOR INJURY.—DISCOVERY OF A NEEDLE .038 M.M. LONG EMBEDDED AND HIDDEN IN THE EYE AND ORBIT.—The case, which had been

admitted under the care of Mr. WORK DODD, was that of a man, æt. 37, who gave the following history: In the morning the patient had been shaking out a new shirt, which was very stiff with starch, when a china button on the sleeve cuff hit him full in the left eye. He had sudden and acute pain, and said it felt as if the eye had been knocked out. On looking at it in the glass he saw a spot of blood on the inner side of the eyeball. The man walked to the hospital, and stated that he did not lose his sight till he got there. Nothing abnormal could be discovered on admission concerning the past history or in the general condition of the patient. Locally the left eye was hyperæmic and very painful, and nearly all sight was lost in it, barely perception of light being left. On examination for an external wound from the blow, there was a doubtful spot, which might have been a solution of continuity, on the inner side just above and .002 m.m. from the edge of the cornea opposite the insertion of the internal rectus muscle. The anterior chamber was filled with blood. The tension was extremely low, -2. For the first two days the patient improved slightly under treatment (mercurial purge, atropine, and boracic lotion), but on the third day there was a good deal of chemosis and the cornea looked very hazy. On the fifth day this condition was unchanged, and, in addition, the eyeball was proptosed and there was considerable orbital cellulitis and what appeared to be hypopyon. Mr. Dodd decided on enucleation of the eye, and suggested before operation the presence of a foreign body. The operation was performed in the usual manner. The optic nerve was severed as far away from the eye as possible. On the eyeball being extracted from the orbit, the broken end of a needle about .038 m.m. (1½ in.) long was seen projecting from the inner part of the eyeball, which last was itself full of pus. The direction of the needle was from the apex of the orbit outwards and forwards to a point outside the cornea on the anterior surface of the eyeball, but there was no hole in this situation through which the needle could have entered. There was nothing in the interior of the eyeball to indicate the track of the needle; there was, however, a small hole through which pus exuded about .002 m.m. to the inner side of the corneal margin. A careful search was made in the orbit and in the eyeball for the point of the needle, but it was not found. Mr. Work Dodd said that the most peculiar thing about the case was that the history of injury from the china button and sleeve was remarkably clear, and was given and repeated without any hesitation or doubt by the man, who was intelligent in all his assertions. Therefore, it must be accepted as a fact that the accident did occur. On the other hand, there was entire absence of any history pointing to a needle being concerned in the accident, and he thought this showed how little the surgeon can rely upon the history given by a patient. (It may be mentioned, however, that, after the operation, the patient, on being shown the needle, remembered that, some time previously, he had been sewing a button-hole in the shirt and had left a needle hanging on a short end of thread.) Mr. Dodd pointed out that the man had been treated for two or three days for contusion and bleeding into the globe, but as the eye did not clear up and became, on the contrary, inflamed, and pus having formed, he commenced to have the suspicion of the presence of a foreign body. The presence of the needle, however, in the eye and orbit, he

said, came as a great surprise, and its method of arrival in these localities was, he considered, very difficult to ascertain. It was possible for the needle to have stuck itself into the eye as a result of shaking the shirt violently, and then to have been hammered home through the ball by the cuff and china button, the hand being probably at once pressed against the eye, the whole occurring as one action. A pointless needle .038 m.m. long would have to travel with enormous rapidity to pierce through the sclera in front and behind, besides passing through the interior of the globe and finishing up towards the orbital apex. The ophthalmoscope, he remarked, could be of no assistance in this case, as the eye was full of blood; and the fact that the tension of the eye was *below* normal, a condition which is not uncommon after contusion of the globe, would not necessarily point to a rupture or to a perforation. These two conditions, and also the presence of a foreign body, lower the tension of the globe. Mr. Dodd said he was glad that he had suggested the presence of a foreign body in the eye. He had only done so because experience had taught him to be always on his guard in this respect. He pointed out also that, as there had been no indication of any such thing, there had been no resort to X-rays.

Ten days after the operation the patient left the hospital perfectly well.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, NOVEMBER 2, 1904.

### THE “BORSTAL” SYSTEM.

WHILE so much talk is being expended—and rightly expended—on the ways of the “degenerate” and the methods of dealing with him, a glance at the other side of the picture may be taken with advantage. Ultra-humanitarianism may bring derision on the heads of all who are striving to establish a more humane code of ethics, just as the reproach of barbarism is frequently brought



against those who err on the side of severity, but there is no denying the fact that the humanitarians are on the up-grade. How far the principles of altruism are compatible with, that is to say advantageous to, the existence of a civilised state is an interesting problem that remains to be worked out. The evidence of the last century is all in favour of the social advance of that state in which regard for others is substituted for brutal indifference. The reason may not always be apparent, but the fact remains, and to medicine must be assigned the first place as a civilising and humanising force. The work and mission of the medical profession brings and keeps its members in constant contact with every class of society down to the lowest, and this at the time when the softer feelings are most apparent; namely, in the time of sickness. Consequently one finds the influence of medicine generally on the side of mercy—to the great advantage of society generally. In no domain more than in that of crime and criminology is this apparent, and in no field has medicine greater triumphs to show. The desire for revenge and for punishment is one of the most elemental of human forces, and the sheer stupidity of giving it unrestricted play in dealing with delinquents has been demonstrated in the criminal annals of every country that possesses annals. Humanity in the treatment of offenders has shown itself to be not only the right but the wise course, and the old savage punishments are, happily, passing out of fashion. The report of the Directors of Convict Prisons, just issued, gives a full account of the working of the so-called "juvenile-adult" system that has been inaugurated at Borstal, and we may say at once that the verdict of the Directors is wholly favourable. This system was inaugurated as an experiment to exploit the plan of treating young criminals with a view to curing, instead of merely punishing, them. From the London prisons were collected cases of youths sentenced to terms of imprisonment of six months and upwards, and these lads were put to learn useful trades, such as carpentering and brick-laying, under beneficent supervision, instead of performing the old routine of purposeless prison tasks. The conduct of the prisoners under the new set of circumstances completely changed; they showed great anxiety to improve, and they were granted extra privileges, became great readers and good chess-players. Nor was this improvement only temporary. So far a hundred and twenty-two "juvenile-adults" have been discharged, and of these, fifty-four are now known to be in employment and leading useful lives, whilst thirty have been lost sight of. Of the remainder, only twenty-four have been re-convicted, and fourteen are still unplaced. Considering that more than a hundred of these cases were hardened young criminals, fifty-one of them having been convicted more than once, and twelve more than three times; that they were discharged in London where they had either no homes or

thoroughly bad homes, and where every temptation existed to glide back to their old haunts; and that the task of supervision after discharge is extremely difficult, one is not surprised that the Directors write enthusiastically about the success of the scheme. They are now planning to extend it so as to reach not only London, but the whole of England and Wales, and to establish it on a permanent basis. Two elements are necessary for a complete cure—time in the prison and supervision afterwards. The first depends on the sentences passed, but it must be borne in mind that the lengthening of sentences is opposed to the whole trend of modern enlightened philanthropic feeling. In order to secure the second condition the Directors suggest the formation of a "Borstal Association," a permanent voluntary agency, to watch over and interest people in the youths when they finally leave prison. We are glad to note that this Association is already on foot, the Home Secretary having consented to act as president, and the Archbishop of Canterbury, the Bishop of London, the Lord Chief Justice, Mr. Asquith and others, as patrons. Now, at last, it seems that rational methods are to have a fair chance in the treatment of criminals, and that the old, blundering brutality—for it has been nothing less—is to become as extinct as it now is in our asylums for the insane. At least we hope so, for it is too early to speak definitely yet. The introduction of lectures on nursing, sanitation, and such-like subjects into female convict prisons that has just been started by some philanthropic ladies—lectures that are greatly appreciated by the prisoners—looks like confirmatory evidence, and we trust the day may not be far distant when criminal therapeutics will become a distinct branch of psychiatry. At all events, we venture to congratulate the Directors of Convict Prisons on the success of the Borstal experiment, and to wish the Borstal Association ready and substantial support in its enlightened labours.

#### TREATMENT OF TRIGEMINAL NEURALGIA.

ALTHOUGH never in itself dangerous to life, trigeminal neuralgia frequently becomes one of the most serious and intractable of diseases. Suffering from incessant and severe pain, to which nothing gives any real relief, it is no wonder that the patient becomes sometimes a moral and physical wreck, broken down by want of sleep and rest, a victim to drug-habits, ultimately degenerating, perhaps, into insanity, or developing a fatal tendency to suicide. In such severe neuralgias medical treatment is, as a rule, unavailing, but, of course, it should be given a thorough trial before surgical methods are thought of. The latter are, however, upon their trial at present, and there are many cases unfortunately in which they appear necessary. Historically, the earliest operation practised for neuralgia was a neurotomy or neurectomy of one or more branches of the

trigeminal nerve. Very often this is found to give considerable relief, though in some cases it entirely fails, and in all the neuralgia tends to recur. It is, however, a quite safe operation, and should always be considered before graver methods are adopted. The graver methods which are in vogue at present agree in the common feature of intracranial neurectomy. Some surgeons think it sufficient to remove the sensory root of the fifth nerve, while others advise the partial or complete excision of the Gasserian ganglion. There is but little difference in the final result whichever practice is adopted, though undoubtedly the removal of the ganglion presents some difficulties of *technique* and special dangers absent in the more simple neurectomy. At the same time, it is believed that there is somewhat less likelihood of recurrence when the ganglion is removed. It need hardly be pointed out that the operation is one of the most serious that can be undertaken, and that it is never justified unless the disease has shown itself intractable to less radical methods. On the other hand, it is inadvisable to postpone the operation until the patient has been reduced by pain and loss of rest to such a condition of weakness as to render any operation a danger. In the performance of the operation itself, the chief risk is from hæmorrhage, though many deaths are reported from shock, from sepsis, and from injury of the brain. The mortality during recent years has probably been 20 per cent., a high figure when it is remembered that the disease itself is not fatal. The difficulty and danger of the operation will probably act as a bar to its adoption by other than daring surgeons, and there is at the present day a tendency to look back to extracranial proceedings with the hope that some treatment may be found which, if not as complete in its final result as intracranial neurectomy, will yet offer hope of prolonged relief. A simple procedure, and one that has already given good results, is that recommended by Sir William Bennett and by Mr. John B. Murphy, of Chicago, namely, the injection into the nerve-trunks of weak solutions of osmic acid. The nerves are exposed and a few drops of a 2 per cent. solution of the acid are injected at several points. Murphy advises that all the main branches of the fifth nerve should be treated in this way, as it is well known that once the neuralgia has affected the nerve, all the branches are likely ultimately to suffer. Murphy's cases are too recent to permit one to say that osmic acid gives permanent cure, but in many of his cases and also of Bennett's there has been a complete cessation of pain for periods of from one to four years. As the operation is entirely devoid of risk it is likely that it will become fashionable in the near future, even if it should be found that the effect is not permanent. It is better that a simple operation should be repeated when necessary than that the life of a patient should be endangered by a superfluous intracranial operation.

## Notes on Current Topics.

### Soap Before School.

THE Education Committee of the London County Council have begun well in appointing a nurse to examine children with regard to cleanliness before entering school in the mornings, and to refer those who appear unsuitable to a doctor, who has authority to refuse admission. This is as it should be. Underfeeding may or may not be due to parental neglect, under-washing always is. It is monstrous to expect clean and careful parents to send their children to sit next to filthy urchins with verminous heads, and it is mere waste of time to insist on other hygienic requirements when the primary step in all health questions, namely, cleanliness, remains untouched. Unfortunately the powers of the education authority seem limited with regard to this question, for at Worship Street Police Court the other day, a batch of summonses against parents for non-attendance—the non-attendance being due to the children having been sent back for dirtiness—were dismissed. An obvious loop-hole exists if this is the state of the law, for a careless parent may purposely neglect to keep his children clean, and then plead that they were excluded from school when he did send them. When the summons is taken out, the children can be cleaned for the purpose of appearing in court. In the cases reported there seems to have been more misunderstanding, for the parents are said to have cleaned the children and taken them back to school, and been again refused admission. If, however, difficulties are likely to arise it would certainly be wise to have full powers conferred on the officers of education authorities to deal with dirty children, or rather their parents, for the County Council Education Committee seem determined to deal with what has been a reproach in days past, and it will be a great pity if their efforts are thwarted or hampered by insufficient powers. If the teaching of the simple laws of hygiene is to be introduced into elementary schools, as we all hope, the first lesson had better be an object-one of the detergent virtues of soap and water, and in so far as example is better than precept will the pupils be impressed with the value of the instruction afforded. Cleanliness is subordinate to godliness only in the sphere of morals; it is subordinate to nothing in the sphere of hygiene.

### Imagination as a Cause of Death.

THERE are two or three stories going the round of the newspapers at present which illustrate the powerful effect the imagination can exercise over the phenomena of life. In one case a girl, suffering from despondency of spirits, is said to have swallowed some harmless fluid in mistake for carbolic acid. She immediately declared that she had poisoned herself, and soon died, though we are left without any information as to the nature of the symptoms, or of the lesions discovered

*post-mortem*. An equally peculiar case is reported from Hull. A young woman asked at a chemist's shop for some laudanum, but the attendant, noticing that she was in an excited condition, supplied her with port wine. Shortly afterwards she was discovered apparently suffering from opium poisoning, and the usual anti-opium treatment was successful. Though we have no authority beyond newspaper currency for either of these stories, there is nothing in them inherently impossible. Apart from the extraordinary mimicry of which hysterical subjects are capable, there are several well-authenticated instances in which death has been the result of quite imaginary causes, or rather of the fright resulting therefrom. Perhaps the best known of these is the case of the jester of a Scottish Court, who, in punishment for some offence being threatened with beheading by a party of courtiers, was then made to kneel before an improvised block, and struck on the neck with a wet towel. To the astonishment of the party, he did not move, and was actually found to be dead.

#### Identification by Finger Prints.

THE inquiry that has just been made into the case of Mr. Beck has not unnaturally excited wide-spread interest, and every respectable citizen would be glad to know that the recurrence of such a heinous blunder will be as impossible in the future as it has always been thought to have been up to the present. Every man has at least one "double," and most people would gladly sacrifice any reflected glory that might shine on them through the achievements of their doubles for the comfortable assurance that the latter's crimes could not possibly be visited on their heads. Fortunately, that practical branch of anthropology which deals with identification has made great strides, and the system now in use by the police is a great advance on the haphazard methods in vogue before 1894. In that year a committee was appointed by the Home Office to inquire into the matter, and their recommendations were accepted. At present each prisoner has an identification card bearing on one side accurate measurements of the essential bodily characteristics, together with a photograph and particulars of complexion, hair, eyes, scars, and other distinctive marks, whilst on the reverse are places for the finger prints. A Scotland Yard inspector mentioned in evidence in a recent case that the Department have no less than 70,000 impressions of finger-marks, and that no two of these are exactly alike. As showing the difficulty of obtaining official recognition for a new art—for the reading of finger-prints is little less—it may be interesting to recall that Sir William Herschel introduced it into Bengal in 1877, and reported favourably on its general applicability. He probably derived his inspiration from finding the practice of signing documents by thumb-marks prevalent in certain parts of India, but in spite of his advocacy the plan was discarded after his

departure. The credit for having reduced the study of finger-prints to an exact science belongs, of course, to Mr. Francis Galton, and it was he who was able by his two great works, "Finger-Prints" and "The Decipherment of Blurred Finger-Prints," to convince the world that the subject had practical bearings beyond those of a hobby for anthropologists. Under the auspices of M. Bertillon the method was many years ago adopted in France. The registration of the papillary ridges of the fingers in indelible form constitutes the most exact single record of identity at present known, and is, moreover, obtained so easily that the future may hold important developments for the art in commercial and general life, beyond even what it has already done for the detection of criminals.

#### Florence Nightingale.

THE recent publication of a biography of Florence Nightingale brings to memory the fact that it is just fifty years ago that the patron saint of the nursing profession and her heroic followers sailed in the time of dire need to succour their wounded and suffering countrymen. We have said the patron saint, for if ever a woman deserves secular canonisation that woman was Florence Nightingale—the founder of modern nursing with its inestimable blessings to the sick, and breaker of red-tape in the Army Hospital Service of her time. The remarkable fact about Florence Nightingale's character was that with a fund of sympathy and skill in nursing individual cases of sickness, she combined truly remarkable powers of organisation, and while it is by the former that her memory will live and be cherished, to her administrative skill and boldness must be assigned the real power she exerted among the authorities. Her influence on the soldiers is illustrated by a touching story told by Sidney Herbert. One of the wounded, speaking of the experiences of his ward, said that Miss Nightingale always found time for a smile and a bright word for some of the sufferers, though their numbers were too great to allow of her recognising and speaking to all; "but," he added, "we could kiss her shadow as it fell, and lay our heads on the pillow again content." Strong woman as she was, the Crimean war broke Miss Nightingale's constitution, and she has led a retired and mostly an invalid life since she returned to England, under the *alias* of "Miss Smith," which she assumed to avoid the ovation prepared for her. Even in her seclusion she has worked hard and steadily for the raising of status and the training of nurses, and from them she has never demanded a lower standard than she lived up to herself. The age of eighty-four still finds her alive to the movements that are taking place in the service she loves, but her active work is over. One might have thought that the fiftieth anniversary of her departure for the Crimea would have been seized upon by nurses as an opportunity for a celebration, for it would be a real and serious loss if the example of Florence

Nightingale were to fade from the memories of her modern successors.

#### Municipal Dentistry.

WE have often urged in these columns that some method of dealing with children's teeth is urgently needed, and that it would be a great advantage if such inspection and treatment could be made available for the working-classes generally. The amount of ill-health and digestive trouble attributable to unsound teeth is incalculable, and returns from every source show the evil to be increasing to an extent that can almost be termed alarming. The difficulties that stand in the way are each of interest in the question, and the all-important question, of expense; certain it is that the latter will never be solved till the former changes considerably. To those who are disposed to make the matter a practical one, the experiences of Germany should be of help. Some of the large towns in that country have both the power and will to appoint municipal dentists, and these officers are already at work. In Strasburg last year 2,666 children were subjected to dental inspection, with the result that no fewer than 2,912 teeth were found too much decayed to be saved, and were therefore extracted, whilst 699 were stopped. The plan that is followed is for each teacher himself to take his class to the dentist, who examines the children one after another, noting on a card the state of the teeth as he finds them. When defects are found the patients are ordered to come up on a Saturday, and the extractions and fillings are then performed. Not only is the importance of sound teeth being recognised in Germany, but Russia—one of the most backward of the great civilised powers in questions of public health—is also taking the matter up, and nine municipal dental institutes for the supervision of teeth have been set up in St. Petersburg alone. These facts, surely, may serve to strengthen the hands of those who would like to see similar advantages conferred on our elementary school children.

#### Intravenous Injection of Salicylates.

IN the administration of many drugs it is known that more excellent results can be obtained when intravenous or subcutaneous injection is practised than when the drug is given by the mouth. Certain drugs, too, lose some of their power when absorbed through the stomach, so that, if a full effect is to be gained, some other method of administration must be practised. This seems to be the case with the salicyl compounds, and for some time various physicians have been in the habit of injecting salicylate of sodium hypodermically with better result than is obtained by the usual method of administration. More recently intravenous injection has been recommended, and has been practised with success by Mendel and others. He usually gives four-grain doses, repeating them at intervals of from twelve hours to three days. In no case were

any ill-effects noticed. In the *technique* of injection the same precautions are necessary as in intravenous injection for any other purpose. The vein should be fully dilated before inserting the needle, and care should be taken that the needle really pierces the vein. In repeating the process, a different vein should be selected. The method of treatment seems to have a wide application, not only in acute rheumatism, for rapid relief has been given in such conditions as lumbago, and the flying pains to which rheumatic patients are so subject in damp weather.

#### Organisms in Sore Throat.

IT has been the experience of most clinical bacteriologists who have to do with the study of cultures from the throat to meet from time to time with cases which present every clinical appearance of diphtheria, but where nevertheless the diphtheria bacillus is absent. Different observers have noted various organisms as being found repeatedly in such cases, but few of them have established a causal relation with the same rigour as has recently been done by Dr. Stone in the States with regard to a diplococcus discovered by him. (a) The diplococcus in question was separated in about a hundred cases, most of which belonged to a quite definite type. There was an acute inflammation of the throat, accompanied by a severe toxæmia, which usually subsided on the second day. In about half the cases there was a membrane present, white in colour, tenacious, and indistinguishable in appearance from the membrane of diphtheria. There was also swelling of the tonsils and œdema of the soft palate and uvula. In addition to cases of this description Stone found the diplococcus in several cases of follicular tonsillitis, and in a few cases of scarlet fever, but in no case was it found in a healthy throat, although over two hundred such were examined. The appearance, staining, and cultural reactions of the organism are sufficiently distinctive, and a positive result is got by the inoculation of animals. In all the ordinary laboratory animals the organism proved to be pathogenic, a diphtheritic exudate appearing on the serous membranes, from which the organism was recovered in pure culture. In no case, however, did an exudate appear on the mucous membranes of the laboratory animals.

#### Meat Extracts in Medicine.

THE exact place of meat extracts in the feeding of invalids is hardly yet grasped by practical physicians. That view is borne out by the sweeping statements that so often run the round of the press, both lay and medical, to the effect that the average meat extract contains no sustenance or nutriment, and that it is merely a stimulant. The average journalist seems to think that when he has uttered those sapient remarks there is nothing more to be said on the matter. Reflect for a moment what stimulation means as a weapon in the hands of the physician faced at the bedside with the problem of how to stay the havoc wrought

(a) *Medical Record*, August 18th, 1904.

by a failing circulation and a thwarted nutrition. As a stimulant alcohol is often his sheet anchor. In many a case we have no hesitation in saying that a good meat extract is a thousand times better than whisky or champagne, inasmuch as its stimulation is not followed by the reaction and depression, bodily and mental, induced by alcohol. Many a time have we seen a patient tided over the rocks into the haven of recovery by the use of the beef-tea and meat extracts that scientists of the study-table order love to deride. Medical men and nurses will do well to think for themselves, and be guided by their own experience rather than by the long-drawn theories of others. Let them choose good extracts made by good firms, and if they want more nutriment therewith let them add milk or cream or whites of eggs.

#### "Sundown" Journalism.

THERE are many men of nervous temperament who never seem fully alive to their work until the end of the day. The dullard of the breakfast-table becomes transformed into the after-dinner wit, while the maiden throws off the listless languor of morning, to emerge later as the beautiful star of evening. But while the fire of nervous energy is at its brightest the ashes of wear and tear are falling at their fastest. It is hardly to be expected that real hard work which shall stand the test of time can be performed late at night, when both body and mind have toiled laboriously throughout a long day. And yet it is well known, especially in the journalistic world, that a considerable proportion of "copy" is written by the light of midnight oil. Dr. T. D. Crothers, in a paper read before the American Medical Editors' Association, has drawn attention to the unequal literary work sent in to medical editors, even by the same authors, which he attributes to the fact that much of it is done after sundown. The literary life is one of stress and strain, and the more so if it be combined with other occupations. In this is probably to be sought the explanation of the "literary patchwork" which is sometimes painfully obvious, even in standard text-books by eminent clinical teachers. The recognition by authors themselves of their inability to do really good work when tired out has, unhappily, led them to the use of artificial brain stimulants. Dr. Crothers considers that many of the articles which appear in the medical journals of his own country convey a distinct impression that they have been written under the influence of extreme fatigue or of drugs, which may account for the hopeless note of failure recognisable in not a few of the ephemeral periodicals of modern times, lay as well as medical.

#### Medical Men in Lay Newspapers.

THE letters of medical men to the daily newspapers on professional subjects are multiplying beyond all bounds. Now, either this is or is not an offence against medical ethics. The London College of Physicians denounce all advertising, direct or indirect, but we find its Censors,

Members and Fellows, nay, even its ex-Presidents, communicating this, that, or the other information under signature to the *Times* and other public prints on cottage hospitals, consumption cures, cancer, X-ray methods, and what-not. The Colleges are no whit greater offenders than many of the members of the honorary staffs of leading Metropolitan and provincial hospitals. What can be said, then, if the rank and file of the profession follow suit, and flood the correspondence columns of the daily press with their views upon any or every matter within the range of medical literature? Where the offenders are to be found in every class it is, perhaps, invidious to mention one. Yet we think the letter of Dr. J. Stenson Hooker to the *Daily News* of October 24th may be briefly alluded to as an example of the superfluous and misplaced energy in question. He informs readers of that journal that the "violet-leaf cure" of cancer has been tried at the Brompton Cancer Hospital, and found wanting. He then proceeds to suggest that red clover top is worthy of trial in the disease mentioned. Surely Dr. Hooker should have made this suggestion to medical men in the columns of the medical journals, and not to the general public. However, many hospital surgeons and physicians have led the way in the same undesirable direction.

#### A Surgeon's Account of the Russian Outrage.

THE secretary of the Royal National Mission to Deep Sea Fishermen has received the following "human" document from the surgeon on board the hospital ship *Joseph and Sarah Miles*, which has the three seriously wounded men on board from the *Crane* :—

"Hospital Mission Ship, *Joseph and Sarah Miles*,  
"Great Northern Fleet, October 24th, 1904.

"Dear Mr. Wood—Before this reaches you, perhaps you are acquainted with the sad news of a dastardly raid on our fishing fleets last Friday night by some foreign battleships. The incident came upon us so sudden and unawares, that we cannot yet realise what it could be. Happily our fleet had no casualty on that fateful night, but the Gamecock fleet, which was working close to us, fared very badly. One of their trawlers sank in a few minutes after being hit by four shells, killing two of the crew and badly wounding the rest. Four of their other trawlers were also hit. The shipwrecked crew were luckily rescued from a watery grave by the crew of another trawler, whose first thought, of course, was to look out for their own mission ship, but before they could find the *Alpha*, they sighted our ship, so they steamed up to us and shouted out for urgent help as some of the wounded men were bleeding to death. The sad news in itself was enough to stagger us. We hauled up our gear at once and launched out our boat, and soon I was aboard the trawler with two of our crew, I have never witnessed such a gory sight as I did on board the trawler. Two men lay on deck with their heads nearly blown to pieces. In the cabin the scene was more heartrending still, when I saw six men stretched about anyhow, bleeding and groaning, with the agony of their wounds. Under the circumstances, I had them all removed on board our ship. With all these wounded men on board, our floating hospital looked like a veritable battlefield. Indeed, it presented a most pathetic sight. It kept me busy with knife and needle the whole of that day, and it was not until late in the night that I had the satisfaction.

of seeing them all safe and snug in their cots, as far as circumstances allowed. But of the six patients three have been allowed to return to their homes, as they were progressing satisfactorily. Of the remaining three, one is quite out of danger, but the other two being very serious cases, I am still anxious about them, and, circumstances permitting, I shall have to send them on to London if they do not progress favourably.—Believe me to be yours sincerely, H. ANKLESARIA."

#### Dr. Ettles as "Medical Referee."

A FORTNIGHT ago, writing on the alleged new treatment (it is really old as the hills) of errors of refraction by massage, we alluded to a public trial of the matter proposed between Dr. Stephen Smith, its "inventor," and a London optician, Mr. Aitchison. On the authority of a daily newspaper, we stated that Dr. Ettles, of the Minorities, had been appointed as referee by Dr. Stephen Smith. This notice was followed a few days later by a letter from a legal gentleman representing Dr. Ettles, disclaiming, on the part of his client, all acquaintance with Dr. Stephen Smith or his methods, and sympathy with anti-vivisection. On receiving this letter we at once proceeded to publish that correction, and to make amends as far as possible for the misapprehension which seemingly we had been led into on the strength of published statements in a London newspaper. It now appears, from a letter in the *St. James's Gazette* of October 28th last, signed by Mr. James Aitchison, that it was he who appointed the referee. "Dr. Ettles, the ophthalmic surgeon," he writes, "whom I appointed to act for me, states—'Mr. Smith will only submit to a test on his own terms, and as those are of such a character as to make the thing an absolute farce, it is out of the question to give way any further.'" Dr. Ettles, it appears, is acting as referee for an optician, not, as we were led to believe, for a qualified medical man. Further comment upon this incident is needless in the columns of a medical journal.

#### Poisoning by Boot-Blackening.

A FATAL case of poisoning, apparently unique in the annals of toxicology, is reported in an American contemporary. (a) A young man, having spent some hours at a dancing party, suddenly fainted in a public café and passed into a state of stupor. Although treated with injections of strychnine, his condition became worse and he died four hours later from paralysis of the circulatory apparatus, no clue being apparent as to the cause of the illness. *Post-mortem*, also, the findings were negative, except that there was an acute desquamative nephritis, and fatty degeneration of the cells, both of the liver and kidney. The tentative diagnosis of poisoning was made, but the cause was quite unknown. Some days later, however, a bottle of shoe-blackening was found in the victim's room, and it was discovered that on the evening of his death he had soaked in this blackening the tan uppers of a pair of canvas boots, and that the colouring had penetrated his stockings, staining

his feet and ankles. Chemical investigation of the substance revealed that the solvent in the blackening was nitrobenzol, an extremely poisonous liquid, much used in the manufacture of cheap perfumes and soaps. Several cases of poisoning by nitrobenzol were already on record. In some, serious results followed a mere breath or two of the vapour, in others on a small dose of the liquid, but we think this is the first where the result is due to absorption through the skin. The occurrence draws attention to the danger of using such a highly toxic substance in the preparation of so many promiscuous wares as soaps, shoe-polish, perfumes, and confections of various sorts. It is a matter of wonder that workers in factories where it is employed do not frequently suffer.

#### PERSONAL.

HIS MAJESTY THE KING has been graciously pleased to confer the title "Royal" upon the Sanitary Institute, the headquarters of which is at the well-known Parkes Museum, Margaret Street, London, and to signify his pleasure that the Institute be known henceforth as the Royal Sanitary Institute.

DR. F. W. MOTT, F.R.S., will deliver the Bowman Lecture of the Ophthalmological Society to-morrow, (Thursday) at 9 p.m., on "The Visual Cortex." The Nettleship Medal will be presented to Mr. Priestley Smith before the lecture. All members of the profession are cordially invited to attend.

THE gold medal of the British Medical Association has been awarded to Sir Constantine Holman for his distinguished services to the British Medical Association, through the South-Eastern Branch, on the Central Council as treasurer and as vice-president; and, further, for his life-long and successful labours for the improvement of the financial conditions of the medical charities.

A COTTAGE hospital has been opened at Tredegar by Lord Tredegar, situated in the park which he had previously presented to the town.

PROFESSOR ROBERT KOCH is to be the recipient of the Nobel Prize in medicine this year.

It is announced that the new Maternity Hospital for Belfast will be opened by Countess Grosvenor on November 7th.

DR. T. ORME DUDFIELD read a paper on "The Need of Sanatoria for Consumptives, and How it may be Supplied," at a special meeting of the Charity Organisation Society on Monday last, at 4.30 p.m., at the Royal United Service Institution.

THE opening demonstration of the winter session of 1904-05 at the Brompton Hospital for Consumption will be given by Dr. Percy Kidd to-day (Wednesday), at 4 p.m., on "Some Points in the Prognosis and Treatment of Pneumonia."

It is announced that his Majesty the King has been pleased to appoint Dr. Bertram C. A. Windle to be president of Queen's College, Cork, in the room of Sir Rowland Blennerhassett, who has resigned. Dr. Windle is at present Dean of the Medical Faculty and professor of Anatomy and Anthropology in the University of Birmingham.

THE current issue of the *Leys Fortnightly*, the magazine of the Leys School, offers congratulations to an Old Leysian, Mr. J. P. Mummery, F.R.C.S., L.R.C.P., on his appointment as one of the honorary medical

(a) *Journ. Amer. Med. Assoc.*, October 1st, 1904.



staff of King Edward VII.'s Hospital for Officers; also Assistant-Surgeon to the North-Eastern Hospital for Children, Hackney Road.

DR. M. M. LOUDON, of Arundel, last week received a handsome presentation from friends and patients on the occasion of his wedding.

ON the 28th ult. the foundation-stone of the new building of the Liverpool Infirmary for Children was laid by the Lady Mayoress, Lady Hampson.

LAST week the remains of the late Lady Dilke were cremated at Woking.

PROFESSOR KOCH has returned to Berlin from Paris, where he had gone to thoroughly inspect the Pasteur Institute, for which he is said to be full of praise and admiration. He leaves for South West Africa in December.

SIR SQUIRE BANCROFT will distribute the prizes and deliver an address to the students of Charing Cross Hospital on Wednesday, November 23rd, 1904, at 4 o'clock.

AT a special meeting of the governors of London Hospital last week Dr. Cecil Wall was elected assistant physician.

DR. ST. AUBYN FARRER, on Monday last, presided over a most successful inaugural general meeting of the newly-formed association of Medical Diplomates of Scotland.

SURGEON-MAJOR GENERAL T. WALSH has been awarded a good service pension in recognition of his long and meritorious services in the Army Medical Department. During the past forty-six years, he has served in many parts of the world, taken part in several campaigns, and has been thrice mentioned in Despatches.

#### THE NEW PRESIDENT OF THE ROYAL COLLEGE OF PHYSICIANS OF IRELAND.



WM. J. SMYLY, M.D. T.C.D., F.R.C.P.

## Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

### SCOTLAND.

INAUGURAL ADDRESS OF THE ROYAL MEDICAL SOCIETY.—The winter session of the Society was opened on October 28th, by Sir James Crichton Browne, who addressed the Society on "The Tendency of Medical Education." It was just forty years, he said, since, as a fourth-year's student, he took possession of the Chair of the Society with feelings of exultation that had known no parallel since. Not the least momentous educational advantage the Society might exert was to keep alive some vestige of idealism among the members. It could not be doubted that the present tendency of medical education was towards materialism. By the very nature of his work the student was accustomed to submit everything to outward and palpable tests. He was nurtured on hard facts which tended, as Oliver Wendell Holmes, averred, to breed a despotic frame of mind in those wrapped up in them. He was in constant danger, unless strongly fortified by natural piety, of having his perceptions materialised and of losing in breadth what he might gain in concentration. Science, when so exclusively pursued, while it expanded the mind in some directions, contracted it in others. A large and varied culture was necessary for the full enjoyment and utilisation of life, a truth which was too apt to be lost sight of in these days of rampant specialism. Physiological and pathological study of the brain and nervous system tended more than anything else to materialise the student's conceptions. From the medical point of view it was convenient to speak of mental modification in terms of brain function, and this serviceable style of expression fostered a habit of thought, and so, more and more, the student was disposed to accept the teachings of leaders of revolt, who contemptuously dismissed their most cherished beliefs, hopes and aspirations, and taught that there was neither creative mind, future being, nor free will, and that life and consciousness were of inorganic origin. Haeckel, with his "Riddle of the Universe" had doubtless confirmed many students in materialism. Haeckel however, with all his subtlety, could not get rid of God, but merely substituted an inane fetish of his own which he labelled substance. Nor was he more successful in disposing of mind and convincing them that it was merely a mechanical function of that form of matter which he called psychoplasm. Like Bathybius, psychoplasm was being discredited by the progress of science. Though matter was the vehicle of mind, it was dominated, transcended, and moulded by it. To medical men a belief in the higher reality was a sustaining thought, amidst all the suffering and death through which their path must lead. This was a world of small cognition, but of mighty inference, and to the thoughtful the inference might dominate the cognition, and the things of faith be more real than those of sense. Materialism was a sorry creed negated by those universal human afflictions that would not be buried in the grave, and must, to the theologian, at least, have a motive and objective. Doubt was needful as a stage in the mind's progress, but it was no abiding place, and in scepticism there was no rest, for most sceptics were harassed by doubts of their own scepticism. Let them contemplate the brain, then, not as a mere collection of atoms or a mass of phosphorised fat, but as a psycho-active body, from which, as long as life lasted, a sheaf of emanation issued infinitely more mysterious than radium. There was the neuron, and behind it the psychon, and they must regard man, not merely as a material object among other material objects, but as a "reasonable soul and human flesh subsisting." The meeting was presided over by Dr. C. J. Shaw, senior president of the Society, and was closed by a cordial vote of thanks to Sir James Crichton Browne.

STUDENTS' RESIDENCE AT EDINBURGH MATERNITY HOSPITAL.—The Milne Murray Lodge, though it has been occupied for some two months now, was only formally opened on the 28th ult. The opening ceremony

was attended by a large company, including Sir John Tuke, M.P., Sir Halliday Croom, Sir John Sibbald, and many other medical men. Professor A. R. Simpson, in declaring the institution open, alluded to the importance of the work which the students had to study. The Lodge accommodates twelve students; it is situated in Lauriston Park, immediately behind the Maternity Hospital.

#### BELFAST.

**ROYAL VICTORIA HOSPITAL.**—The winter session at the Belfast Medical School was opened last week with an address given at the Royal Victoria Hospital by Mr. Andrew Fullerton, F.R.C.S.I. The speaker dwelt first on the necessity of a good preliminary training in chemistry, biology, and physics, for the student who wished to make the most use of his hospital experience. Comparing the new hospital with the old one, he said that the public were inclined to show their appreciation of the new by abusing the advantages it afforded, and in this connection he touched on the general question of hospital abuse, both in Ireland and England. The necessity for attention to clinical work was impressed on the students. It might be all very well, Mr. Fullerton said, to read up the account of a muscle or of a physiological experiment in a book, but it was a poor business to read the symptoms of a disease when they could actually see them at the bedside of the patient. On the other hand, how pleasant it was to read up a disease, the symptoms of which one had just studied in the ward. The laziest and most indolent student could hardly fail to get a fair idea of the more common surgical and medical ailments if he attended the hospital extern and wards diligently, even if he did not read a line. Dealing with club and dispensary practice, Mr. Fullerton said that it had been the ruin of the medical profession, and the fate of the club doctor was often too miserable for description. The matter would not be satisfactorily dealt with till young medical men refused to take posts vacated by those who had been sweated and imposed upon beyond endurance. At the conclusion of the address a vote of thanks was moved by Professor Sinclair, seconded by Professor Byers, and supported by Dr. Henry O'Neill, and passed with enthusiasm by the students.

**THE NEW WORKHOUSE SANATORIUM.**—At their last meeting the Belfast Guardians had under consideration the constitution and pay of the nursing and medical staffs of the new sanatorium at Whitehouse. They propose that the salary of the resident medical officer be £12 per annum, with rations and apartments, but that instead of making a permanent appointment, they should give the post to any one of the medical officers of the city workhouse who desired it, for a period of six months at a time. The salary of the visiting medical officer is also fixed at £120 per annum, and it was arranged that Dr. Hall, the senior medical attendant of the workhouse, should be asked to take this post temporarily. One of the guardians, Dr. Ritchie, thought that they could not expect Dr. Hall to devote much time to the work at such a small salary, and proposed that he should be paid £200, increasing to £300; but the proposal did not find favour with the majority.

**THE SMALL-POX OUTBREAK.**—During the first ten days of October no fresh cases of small-pox were discovered in Belfast, but since then there have been seventeen cases, including nine last week. Four of the cases were removed in one day from a house in the Sandy Row district of Belfast, and two more cases from the same house shortly after; four of these six cases being unvaccinated children. Two other unvaccinated children in the same street have contracted the disease and have been removed to the hospital at Purdysburn, where eight of the seventeen patients now under treatment are unvaccinated! Nearly all the cases at present under treatment belong to the same connection, the adults of the different families working together. The general type of the disease is comparatively mild, but the unvaccinated cases are, as usual, severe, and at least one is likely to prove fatal.

## Correspondence.

### THE VERNON HARCOURT INHALER.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*  
SIR,—In your issue of October 26th you publish a letter from an anonymous correspondent in reference to a death which recently occurred under chloroform at University College Hospital. One usually ignores unsigned letters, but as you extend your editorial ægis over your anonymous correspondent's letter, and say rightly that one should not shrink from adverse criticism, I will answer the two queries contained in the communication in question. First, the "Vernon Harcourt" inhaler was not used on the occasion referred to. In the second place, I am informed by the house-surgeon who administered the chloroform that he was compelled to use a Schimmelbusch's mask with a drop bottle as the seat of operation rendered the employment of a closely-fitting mask, such as that attached to the "Vernon Harcourt" inhaler an impossibility. As a matter of fact, I regret that he did not use the last-named apparatus during the induction of narcosis, for I am convinced that it affords the best chance of safety for patients who, like the poor woman who died, run so grave a risk during the induction of anaesthesia, owing to antecedent disease and habits. Narcosis having been established, the open method could for the convenience of the operation have been adopted.

I am, Sir, yours truly,

DUDLEY BUXTON.

82, Mortimer Street, Cavendish Square, W.

### THE TREATMENT OF INOPERABLE CANCER.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*  
SIR,—With reference to the communication from Mr. George E. Keith, published in your last issue, reverting to my paper on the treatment of "inoperable cancer," I desire, with your permission, to make one or two comments thereon. It is necessary in the first place to point out to your readers my position with respect to Mr. G. Keith and the treatment which I have advocated in my paper. In 1902 I commenced treating cases of uterine fibroid by means of hypodermic injections of iodipin. My procedure and details of treatment were freely made known to Mr. G. Keith, and published. Having learned all I had to teach, I was startled later to hear he had introduced a mixture for hypodermic use in cases of cancer. I have no wish to deprive Mr. G. Keith of any credit which may be his due, but I was certainly aware at the time of hypodermic medication in cancer. Subsequently, on inquiry as to the precise composition of his mixture, he refused to divulge its nature except on the promise that I would not reveal it till he was ready for publication. Acting on this promise I have neither revealed it nor tried it.

I have only one word more to add, viz., that Mr. G. Keith's mixture was neither chian turpentine nor soap solution, and I therefore still claim that the administration of chian turpentine by hypodermic medication is original, as far as I am concerned, and in justice to myself and others, I would ask Mr. G. Keith to make known the mixture he told me of.

I am, Sir, yours truly,

JOHN A. SHAW-MACKENZIE.

42 Green Street, Park Lane, W.  
October 27th, 1904.

## Obituary.

**JAMES BURN RUSSELL, B.A., M.D.Glas., LL.D.**  
SCOTLAND has lost a distinguished member of the medical profession in the person of Dr. James Burn Russell, M.D., LL.D., medical member of the Local Government Board for Scotland, and formerly medical officer of health for Glasgow, who died suddenly in Edinburgh at the age of sixty-seven. He was formerly physician-superintendent of the City of Glasgow Fever Hospital, assistant medical officer of the Town's

Hospital, Glasgow, and medical officer of health for the city. In 1885 the University of Glasgow conferred on him its honorary LL.D. degree; in 1891 he carried off the Stewart prize of the British Medical Association, and in 1899 won the Bisset Hawkins Memorial Medal of the Royal College of Physicians, London. He was a Fellow of many learned societies. Dr. Russell had paid much attention to the question of the housing of the poor and had written largely on public health. While his loss to public health work in Scotland will be great, it will be little less felt by a large circle of friends and fellow workers.

ANGEL MONEY, M.D.LOND., F.R.C.P.

THE news of the sudden death of Dr. Angel Money, at Sydney, will be read with regret by those who knew him formerly in London. He entered as a student of the Medical Faculty of the University of London in 1874, when his brilliant qualities soon brought him into prominence, and his ability and enthusiasm, coupled as they were with untiring industry, soon attracted attention. He became house physician and house surgeon at University College Hospital. Subsequently he was appointed physician to out-patients and house-surgeon to the General Lying-in Hospital, Lambeth, where he did good work in investigating the condition of the heart in the later months of pregnancy. He was later appointed medical registrar to the Hospital for Sick Children, Great Ormond Street, and assistant physician in 1885. In 1887 he became assistant physician and assistant professor of clinical medicine, University College Hospital. He worked hard and wrote much, among his books being "A Treatise on Disease in Children"; he was a constant attendant and a frequent speaker at the medical societies in London, when he was attacked by illness. He was compelled to resign his appointments, and in 1892 he went out to Sydney. Here again he acquired a considerable practice. His health gave way again, and a career of brilliant promise was cut short.

DR. ROBERT H. MOORE, F.R.C.S.

WE regret to have to chronicle the death of one of the oldest medical men, and probably the oldest dental surgeon in Ireland, Dr. R. H. Moore, of 29, Uppen Merrion Street, Dublin, who died on October 24th, in his eighty-ninth year. Robert Henry Moore studied his profession at the School of the Royal College of Surgeons in the early thirties, and in 1844 obtained the Fellowship of the College. He was at an early stage in his career apprenticed to Mr. Samuel McLean, who was one of the most important dental surgeons of his day. So earnestly did he devote himself to the practice of the special branch of his profession which he had selected, that not only did he enjoy a large practice, but also filled the post of Surgeon-Dentist in Ordinary to several successive Lords-Lieutenant of Ireland. He also represented the dental profession on the Council of the Royal College of Surgeons, and when the Incorporated Dental Hospital was established he was elected its senior consulting dental surgeon. Dr. Moore lived a strenuous active life, and when he retired from active practice he had well earned the rest he obtained. He leaves many friends to mourn his loss.

### SPECIAL REPORT OF THE CENTRAL MIDWIVES BOARD.

MEETING HELD OCTOBER 27TH, 1904.

The President, Dr. CHAMPNEYS, in the chair.

THE President began by proposing a vote of condolence with the widow and family of Mr. Heywood Johnstone, saying the Board would always remember him as a genial and practical helper in all its concerns. The vote was unanimously carried. Among minor business it was discussed whether a certified midwife acting as nurse under a doctor was bound to give notice to the authorities, the President remarking that a midwife might be one month in Yorkshire and the next in London.

Mr. Ward Cousins argued that sometimes a midwife was "practising"—i.e., conducting—the case alone, and sometimes not.

The President considered a midwife acting under a doctor to be only a glorified monthly nurse, but if she were resident and practising in a place she ought to give notice to the authorities, which was then put to the vote and carried.

It was also agreed to discuss *in camera* three cases of a legal nature at an extra meeting to be held on November 3rd. Applications for approval as institutions for the training of midwives under Section 3 were considered from the Secretary of State for War on behalf of hospitals for soldiers' wives and children at Chatham, Portsmouth, and Woolwich, it being decided to grant such permission in due proportion to the number of births, as these institutions, in common with another, the Withington Infirmary, had clearly not understood the rule of personal supervision, but had allowed several students to claim attendances at one lying-in.

The final consideration of the examination scheme was then proceeded with, which, in its amended form, we publish in another column.

Mr. Ward Cousins next inquired whether a midwife could give a notification of a still birth to the authorities, the President replying that the question would be decided by the General Medical Council.

Miss Paget then moved that the period of the approval of any certified midwife (duly qualified so to act) for the purpose of signing Forms III. and IV. under Rule C. I (2) shall expire on March 31st next following such approval, but may be renewed from time to time for the period of one year as often as the Board shall think fit. Provided that no approval granted by the Board before March 31st, 1905, shall require renewal before March 31st, 1906, which was carried. The date of next meeting was fixed for November 24th.

### Medical News.

Royal Army Medical Corps (Volunteers).

THE following appointments have been officially gazetted:—Surgeon Lieutenant-Colonel J. Cantlie, M.B., 7th Middlesex (London Scottish) Volunteer Rifle Corps, and Honorary Lieut.-Colonel Commandant Maidstone Companies, Royal Army Medical Corps (Volunteers), is appointed to the Honorary Colonelcy of the Companies.

Royal College of Surgeons of Edinburgh.

At a meeting of the College held on the 19th ult. the following gentlemen, having passed the requisite examinations, were admitted Fellows of the College:—Wilfrid Allport, M.B., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond., Birmingham; Simon Alexander Ballantyne, M.B., Ch.B.Edin., Abington; Donald Duff, L.R.C.S.E., Glasgow; Harold Dyer, M.R.C.S.Eng., L.R.C.P.Lond., South Croydon; Duncan Campbell Lloyd Fitzwilliams, M.B., Ch.B.Edin., Edinburgh; James Graham, M.B., C.M.Edin., Cockermonth; Donald Alexander Hingston, M.D., Laval, Montreal; Christopher Tredwell Holford, M.R.C.S.Eng., L.R.C.P.Lond., Birmingham; Edwin Henry Irwin, M.B., C.M.Edin., Co. Monaghan; Robert Bathgate Johnston, L.R.C.S.E., Edinburgh; Nicholas John Kalomiris, M.R.C.S.Eng., L.R.C.P.Lond., London, S.E.; James Graham McBride, M.B., Ch.B.Edin., Edinburgh; Daniel Sayre Mackay, M.D., C.M. McGill, L.R.C.S.E., Nova Scotia; Mrigendralal Mitra, L.M. & S., Punjab, Calcutta; William Newlands, M.B., Ch.B.Edin., Edinburgh; Robert Ramsey, M.B., Ch.B.Glasg., Glasgow; Athelstan John Henton Saw, M.D., Ch.B.Camb., Perth, West Australia; Fred William Sumner, M.B., Ch.B., Camb., M.R.C.S.Eng., L.R.C.P.Lond., Preston, Lancs.; John Charles Venniker, M.D., Ch.B.Durh., M.R.C.S.Eng., L.R.C.P.Lond., London, W.; David Llewelyn Williams, L.R.C.S.E., Edinburgh; and Oswald Samuel Wraith, L.R.C.S.E., M.D.Durh., Darwen, Lancs.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have been awarded the Diploma of the Society (L.S.A.), entitling them to practise medicine surgery, and midwifery: A. A. Angelis, W. H. A. Elliott, B. H. Hirst, E. E. Tucker.

## 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.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning proofs.

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

**Mr. A. E. HOLDEN.**—Your communication was received as the journal was on the press.

**Mr. FLEETWOOD.**—In reply to your queries: (a) the subject is a complicated one and has not been finally determined. (b) The value particularly attached to the employment of Mellin's Food is its exceptional richness in maltose, the analogue of lactose. (c) Dr. Haig's work ought to be consulted.

**E. L.**—See reply to Mr. Holden.

### "PARTING IS SUCH SWEET SORROW."

Nature removes our teeth and hair;  
And while we think it most unfair,  
Harder it is to understand  
Why we should part with Prostate Gland!  
Perhaps Appendix in addition  
Before we're summoned to Perdition.  
The Prostate Gland! The Prostate Gland!  
You hear of it on every hand,  
"Appendicitis filled a page,  
Now Prostatitis is the rage,"  
And while the gland supply is ample  
Just make an extract, Try a Sample!  
It really might be found to answer  
Perchance a real cure for Cancer.  
"Man wants but little here below"  
When Prostate and Appendix go.—A.D.

**SKERRINGTON.**—There is not the slightest danger in any ordinary X-ray exposure conducted by a skilled medical man. At the same time it has been well known for five or six years that operators are liable to intractable injuries that may assume a malignant type. Here again the careful operator may readily ensure himself against injury by taking ordinary precautions. The newspapers have rediscovered a recent history, and we regret the names of medical men should be involved.

**W.C.S.**—It is impossible to discuss matters that have not a direct or indirect medical interest in the columns of a medical journal, however interesting such matter may be from a philosophical point of view. The immense ground covered by the scientific and the politico-social and economic phases of medical life renders the pressure on space more and more exacting.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 2nd.

**OBSTETRICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. H. H. Dauber and others. Paper:—Dr. H. R. Spencer: Three Cases of Cancer of the Cervix complicating Labour in advanced Pregnancy, the Patients remaining well Eleven, Eight and a half, and Eight Years after High Amputation of the Cervix.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. J. Cantile: Clinique. (Surgical.) 5.15 p.m. Dr. D. Williams: The Therapeutics of some Common Ailments.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (North-Eastern Fever Hospital St. Ann's Road, N.).—2.30 p.m. Dr. H. Cuff: Demonstration on Fevers.

THURSDAY, NOVEMBER 3rd.

**RONTGEN SOCIETY** (20 Hanover Square, W.).—8.15 p.m. Ordinary General Meeting. The Presidential Address.

**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. Hutobinson: Clinique. (Surgical.) 5.15 p.m. Dr. W. Ewart: The Treatment of Acute Heart Disease and Loss of Compensation.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fileroy Square, W.).—5 p.m. Lecture: Mr. H. Barwell: Principles of Treatment of Laryngeal Cases (illustrated by cases). (Post-Graduate Course.)

FRIDAY, NOVEMBER 4th.

**WEST KENT MEDICO-CHIRURGICAL SOCIETY** (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Paper:—Dr. Turner: The Treatment of Scarlet Fever, Diphtheria, and Enteric Fever at the South-Eastern Hospital.

**WEST LONDON MEDICO-CHIRURGICAL SOCIETY** (West London Hospital, Hammersmith, W.).—8 p.m. Clinical Evening. Cases will be shown by Dr. F. S. Abraham, Dr. A. E. Russell, Mr. A. Baldwin, Mr. B. L. Paton, Mr. G. Simpson, and others.

**SOCIETY OF ANAESTHETISTS** (20 Hanover Square, W.).—Discussion of the Vernon-Harcourt Chloroform Inhaler (opened by Mr. E. Wilson); Dr. D. Burton, Dr. Silk, Dr. Proby-Williams, Dr. Blumfeld, and others will take part.

**LARYNGOLOGICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—5 p.m. Cases, Specimens, &c. will be shown by Mr. E. B. Waggett, Mr. P. de Sauti, Dr. E. F. Potter, Mr. A. H. Cheate, Mr. A. Roberts, Dr. Nelson, Mr. H. B. Robinson, and others.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Dr. L. Lack: Clinique. (Throat.)

## Vacancies.

**Royal London Ophthalmic Hospital** (Moorfields Eye Hospital), City Road, E.C.—Senior House Surgeon. Salary £100 per annum, with board and residence in the Hospital. Applications immediately to Robert J. Bland, Secretary.

**Warnford Hospital, Leamington.**—House Surgeon. Salary £100 per annum, with board, washing, and apartments. Applications to G. T. Poole, Secretary.

**City of London Asylum, near Dartford, Kent.**—Medical Superintendent. Salary £800 per annum, with unfurnished house, coal, light, laundry, and garden produce. Applications to Charles Fitch, Clerk to the Visiting Committee, Guildhall, E.C.

**Nottingham Children's Hospital.**—House Surgeon. Salary £100 per annum, with board and residence. Applications to A. F. Kirby, Secretary, Albion Chambers, King Street, Nottingham.

**Peckham House Asylum.**—Second Assistant Medical Officer. Salary £150 per annum. Application to the Resident Licentiate, Peckham House, Peckham, S.E.

**St. Mary's Hospital for Sick Children, Plaistow, E.**—Resident Medical Officer. Salary £100 per annum, with board, residence, and laundry. Applications to Percy J. Glenton, Secretary.

**Wolverhampton and Midland Counties Eye Infirmary.**—House Surgeon. Salary £70 per annum, with rooms, board, and washing. Applications to the Secretary.

**Royal Portsmouth Hospital.**—Senior House Surgeon. Salary £100 per annum, with board, residence, &c. Applications to J. E. Neil, Secretary.

**Smedley's Hydropathic Establishment, Matlock.**—Resident Physician. Salary £150 per annum. Applications to Dr. Harbison, Smedley's, Matlock.

## Appointments.

**BUCHANAN, P.S., M.B., &c.**—Outdoor Midwifery Department, Glasgow Public Dispensary.

**GRANT, W. F., M.Sc., M.B., Ch.B. Vict., M.R.C.S., L.R.C.P.**, Junior House Surgeon to the Birkenhead Borough Hospital.

**KALONIRIS, N., L.R.C.P. Lond., F.R.C.S.**, Clinical Assistant to the Chelsea Hospital for Women.

**NAIRN, A. BALFOUR, L.R.C.P. & S. Edin., L.F.P.S. Glasg.**, Pathologist and Assistant Medical Officer to the West Riding Asylum, Wakefield.

**ORMEROD, HENRY LAWRENCE, M.D., B.Ch., E.U.I., L.R.C.P. Lond., M.R.C.S.**, Medical Officer for the Henbury District by the Thornbury Guardians.

**PAINE, ALEXANDER, M.D., B.S. Lond., D.P.H.**, Joint Pathologist with Dr. D. J. Morgan to the Cancer Hospital.

**PARSONS, WALTER BROCK, M.R.C.S., L.R.C.P. Lond.**, Assistant Anaesthetist to the Royal Dental Hospital, Leicester Square.

**ROSS, J. A., M.B., Ch.B. Edin.**, Junior House Surgeon to the Croyden General Hospital.

**ROYWELL, WILFRED F., M.B., B.Ch. Vict.**, Third Assistant Medical Officer at the Manchester Union Infirmary, Crumpsall.

**TAYLOR, E. GRAHAM, M.B., &c.**, Gynaecological Department of Glasgow Public Dispensary.

**WALL, E. C. B., M.D. Lond.**, Assistant Physician at the London Hospital.

**WALLACE, A. TAYLOR, L.D.S.R.C.S. Edg.**, Honorary Dental Surgeon to the Convalescent Home at Western-super-Mare.

## Marriages.

**GILLIAT—DUKE.**—On October 27th, at St. Nicholas's Church, Bathampton, Somerset, Algernon Edward Gilliat, eldest son of Mr. Algernon Gilliat, of Stoke Poges, Bucks, to Eva Marjory, only surviving daughter of the late Dr. Douglas Duke, of Cannes, France, and of Mrs. Duke, of 1 Sydney Place, Bath.

**LONDON—BRIGGS.**—On October 27th, at the Parish Church, Britwell Salome, Marcus Moore London, M.D., of Tarundel, Sussex, to Florence Mary, only daughter of the late Hickson Briggs, of Ialeworth, and of Mrs. Biggs, of Britwell Priory, Oxfordshire.

## Deaths.

**MACKENZIE.**—At Foo-Chow, A. E. Maud, the beloved wife of Rev. Marcus Mackenzie, M.B. (C.M.S., Fuh-ning, China), and daughter of the late Rev. J. A. Aston, of St. John's, Deptford, aged 29.

**WILLIAMS-FREEMAN.**—On October 28th, at Weyhill, Andover, Lorna Augusta, infant daughter of John P. Williams-Freeman, M.D., aged 10 months.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, NOVEMBER 9, 1904.

No. 19.

## Original Communications.

### CANCER OF THE LARYNX. (a)

By SIR FELIX SEMON, C.V.O., M.D. Berlin,  
F.R.C.P. Lond.

Physician-Extraordinary to his Majesty the King.

MR. PRESIDENT AND GENTLEMEN.—The keynote of the observations which I shall have the honour of addressing to you was struck in a discussion on malignant disease of the larynx at the meeting of the American Laryngological Association in 1902, when Dr. Bryson Delavan stated that it was time "that the discussion of these subjects upon theoretical grounds should give place to careful studies of what was actually being accomplished by practical men."

It is a matter of history that the case of the late German Emperor represents the turning point of modern knowledge of cancer of the larynx. Until then, that knowledge had been incomplete and unsatisfactory. Very little was known about the early symptoms and early laryngoscopic appearances of the disease, and as a rule its existence was only recognised when it was in an advanced stage. Up to 1878 many cases were in such circumstances treated by thyrotomy, an operation which, though positively ideal in early stages is quite insufficient, as we now know, when the disease is more advanced. The results were naturally disastrous and led, after Paul Bruns' sweeping condemnation in 1878, (b) to almost complete abandonment for a time of thyrotomy in malignant disease of the larynx. The more severe forms of radical operation—total and hemi-laryngectomy—enthusiastically welcomed when first introduced, did not at once justify the hopes which had been raised, and in the early "eighties" of the last century the outlook for the unfortunate patient afflicted with laryngeal cancer was grave in the extreme.

There can be no doubt that the sympathetic interest with which the whole world followed the melancholy course of the Emperor Frederick's illness gave a sudden and universal impetus towards a closer study and better understanding of that formidable disease. First came the revival of the deplorable doctrine of the late Mr. Lennox Browne, (c) *viz.*, that benign laryngeal growths were specially liable to undergo malignant degeneration after intralaryngeal operation. This was followed by the publication of my "Collective Investigation," (d) undertaken with the help of most of the prominent laryngologists of the world, to test the truth of this assertion. The material thus collected enabled me not only to show the complete want of foundation of Mr. Browne's contention, but also to establish more definitely than had hitherto been done the differential diagnosis between benign and the early stages of malignant neoplasms of the larynx, and to discuss fully

the position and relative importance of the microscopic examination of intralaryngeally removed fragments of new growths for the differential diagnosis between the benign and malignant forms.

Before the report of the "Collective Investigation," which was published in instalments, had been concluded, Professor Bernhard Fraenkel, of Berlin, published his remarkable paper, "Laryngeal Cancer, its Diagnosis and Treatment," (a) in which, besides studying the histological characteristics of laryngeal cancer, he advocated anew in suitable cases the treatment by intralaryngeal operation, which he had first proposed in 1886. In reply, I lost no time in urging in the concluding chapter of the "Collective Investigation" some of the objections which seemed to me obvious against adopting intralaryngeal instrumentation as a suitable means of combating laryngeal cancer. About the same time Mr. H. T. Butlin (b) inaugurated a new era in the treatment of intrinsic cancer of the larynx by showing that owing to our diagnostic progress it was possible to obtain the same results in early cases by thyrotomy which had previously been believed to be unobtainable by anything short of hemi-laryngectomy. From this time onwards the remarkable national cleavage took place which characterises our present situation. Previously to the Emperor's illness, however imperfect and unsatisfactory our knowledge of laryngeal cancer may have been, there had at any rate been no national differences, and the opinions with regard to diagnosis and treatment which dominated our actions were, whether right or wrong, entertained by the whole laryngological world. From 1889, all this changed. A number of German laryngologists, headed by Jurasz (c) and following Fraenkel's lead, advocated, and still advocate, intralaryngeal operations in apparently suitable cases of malignant disease of the larynx. They have found allies in France, in Spain, and in America, whilst apart from myself, the employment of intralaryngeal surgery in cases of malignant disease of the larynx has been deprecated by Schrötter, Chiari, and Paul Bruns. On the other hand, my own statements concerning the diagnostic importance of some of the early signs of laryngeal cancer have met, I am afraid, with but little attention in other countries besides Great Britain, and, similarly, it is astonishing to observe how little impression the reports of British successes obtained by thyrotomy in suitable cases seem to have made upon the minds of operators on the continent of Europe and in America.

In 1900, Dr. John Mackenzie read at the meeting of the American Laryngological Association a paper entitled "A Plea for the Early Naked-eye Diagnosis and removal of the Entire Organ, with a Neighbouring Area of Possible Lymphatic Infection in Cancer of the Larynx." The contentions of this remarkable paper, with but few exceptions, run straight against all established teaching. The author demands naked-eye diagnosis of malignant disease of the larynx in its early stages to the complete exclusion of the intralaryngeal removal of a fragment for the purposes of microscopical

(a) Abstract of an Address delivered before the Laryngological Section of the New York Academy of Medicine, November 2nd, 1904.

(b) "Die Laryngotomie zur Entfernung Endolaryngealer Neubildungen," 1878. Berlin. August Hirschwald.

(c) See, for instance, "Zur Frage der Radicaloperation bei Bösartigen Kehlkopf-Neubildungen," Fraenkel's *Archiv für Laryngologie* Bd. IV., H. 3, 1897.

(d) Introductory Remarks to the Discussion of the Operative Treatment of Malignant Disease of the Larynx, at the meeting of the British Medical Association at Swansea, July, 1903, *Brit. Med. Journ.*, October 31st, 1903.

(a) *Brit. Med. Journ.*, May 8th, June 4th (Editorial), 11th, 18th and 26th, and July 16th, 1887.

(b) "Internationales Centralblatt für Laryngologie," 1888-89.

(c) Heymann's "Handbuch der Laryngologie," Bd. I, Zweite Hälfte, 1896.

examination. The latter he rejects *in toto*, and urges against its employment that the removal of tissues for examination subjects the patient to the dangers of auto-infection at the point of incision and to metastasis elsewhere, that it stimulates the local growth of cancer, and that the method is often inconclusive, misleading, and sometimes practically impossible. In the further course of his observations he emphatically condemns thyrotomy, and his teaching culminates in the statement that there was only one rational method, in the majority of cases at least, of dealing with cancer of the larynx: "Early total extirpation of the entire organ with its tributary lymphatics and glands, whether the latter be apparently diseased or not, is the only possible safeguard against local recurrence or metastasis." When I first read this paper I was not inclined to take it seriously. Throughout it substitutes theory for practice to such a degree, threatens hypothetical dangers which experience has shown practically to be non-existent, totally disregards the actual results obtained by trustworthy observers, and indiscriminately demands extreme measures where experience has shown milder ones to suffice, that I considered a detailed refutation unnecessary, and therefore referred to it in a chaffing spirit in the course of some lectures I delivered in 1901. (a) But, to my regret, the matter has not ended there. In 1902, Dr. Mackenzie, in a further discussion on cancer of the larynx, which took place at the meeting of the American Laryngological Association, declared that he abided by his views, and since then I have been credibly informed that these views have exercised a perturbing influence upon not a few minds on this side of the Atlantic. I shall therefore content myself with discussing the four most important of Dr. Mackenzie's assertions only. These are the following: (1) That the naked-eye method of diagnosis is a comparatively neglected method; (2) that the microscopical examination of a fragment intralaryngeally removed is to be totally rejected; (3) that early total extirpation of the entire organ with its tributary lymphatics and glands, whether the latter be apparently diseased or not, is the only possible safeguard against local recurrence or metastasis; and (4) that thyrotomy is not up-to-date surgery, is in direct defiance of the rules that should govern us in the treatment of laryngeal cancer, and is a reversion to, and a resurrection of, a method of procedure that was discredited and abandoned half a century ago.

1. According to Dr. Mackenzie, the naked-eye diagnosis is a comparatively neglected method. What is the real state of this question? In the introduction I have referred to my endeavours to promote the knowledge of the subjective signs and laryngoscopic appearances of the early stages of malignant disease of the larynx. Having in 1886 (b) and 1888 (c) enumerated in two communications of mine some of these signs, I reverted to the subject at greater length in the "Collective Investigation" I undertook in 1888 and devoted an entire chapter of my report to a systematic description of the minute details which in a number of cases had enabled me to diagnose laryngeal cancer at a comparatively early period. This description has, so far as I know, remained up to this moment the last word on the subject. When I returned eight years afterwards to this question (d) I stated, even more emphatically than I had done in 1888, *verbatim* as follows: "Unfortunately, with the only exception of those cases in which it is possible to intralaryngeally remove a fragment of the new growth and to establish its epitheliomatous nature by the help of the microscope, *not one single sign* in the early stages of malignant neoplasm of the larynx is in itself so characteristic that it establishes with absolute certainty the malignant nature of the formation. The contour, the seat, the condition of

the surface, the colour of the new growth itself, the condition of the neighbourhood, the mobility of the vocal cord, the age of the patient, other subjective symptoms, they all may and will assist the experienced eye in making the diagnosis, particularly when several of them *jointly* raise such suspicion, but all of them are not *absolutely* characteristic in the earliest stages, and the possibility of a mistake is not excluded in some less characteristic cases." Butlin, too, has correctly characterised the situation when he said in his introductory paper on the occasion of a discussion on the early radical treatment of laryngeal cancer (e) that "we were still in this position, and were likely to remain in it for a good many years to come. That we must admit that there are three classes of cases: The first, in which anyone and everyone can make the diagnosis; the second, in which the better instructed or more experienced make it and others do not; and the third class in which the conditions are so obscure that no one can make the diagnosis, unless the larynx is opened and in some of which it is even then difficult to be sure of the nature of the disease."

That, gentlemen, is, I maintain, a true description of the present state of matters. However much we all desire—and I do not yield to Dr. Mackenzie in that respect—further to advance our clinical knowledge of the early stages of laryngeal cancer, we have not made diagnostic progress since 1888. Although, no doubt, in the great majority of cases an experienced observer will make the correct diagnosis of intrinsic cancer of the larynx in its early stages from clinical signs alone, the possibility of occasional errors is anything but excluded. They have occurred in the practice of other experienced observers and they have occurred in my own. And what is most important in view of Dr. Mackenzie's light-hearted advice—*viz.*, to perform extirpation of the whole larynx with its tributary lymphatics and glands on the strength of naked-eye diagnosis alone—is the fact noticed by others (b) as well as by myself, that when an error in diagnosis is committed it is more commonly on the side of regarding an innocent growth as a malignant one than a malignant growth as an innocent one. In the present connection, speaking on the strength of large personal experience, I only wish to say that I maintain most strongly that our clinical knowledge of these stages is not yet perfect and that occasional diagnostic mistakes are unavoidable. Dr. Mackenzie himself admits that "there is unfortunately no solitary unequivocal symptom or laryngoscopic sign of cancer," and seems to allow that "after weighing carefully all the facts of the case in our possession a reasonable doubt may remain as to the diagnosis." Just so; but what is the logical conclusion, gentlemen, to which all the foregoing drives us? Surely that it is the positive and imperative duty of every observer to resort to *every* method of diagnosis that could possibly help him in establishing a certain diagnosis before radical operation of any kind is performed.

2. Here we come to the second of his contentions—*viz.*, to the total rejection of the microscope as a diagnostic help in cases of suspected laryngeal growth. His reasons for opposing intralaryngeal removal of a piece for microscopic examination are that such removal "subjects the patient at once to the dangers of auto-infection at the point of incision and to metastasis elsewhere, that it stimulates the local growth of cancer, and that the method is often inconclusive, misleading, and sometimes practically impossible."

I fully admit the possibility of auto-infection in laryngeal cancer, particularly when the surface opposite to an ulcerating new growth should have lost its covering epithelium. But when this theoretical possibility has been admitted and when the practical question is now asked: How often has such inoculation been actually observed? I am happily in the position to state that so far as my literary knowledge goes, there are only three cases recorded as examples of local auto-infection in laryngeal cancer. Seeing the

(a) "Some Thoughts on the Principles of Local Treatment in Diseases of the Upper Air-Passages," *Brit. Med. Journ.*, October 9th, 1901.

(b) A Case of Partial Extirpation of the Larynx, &c., "Transactions of the Clinical Society of London," 1904.

(c) "Die Krankheit Kaiser Friedrich des Dritten." Internationales Centralblatt für Laryngologie, Bd. V, H. 2, 1888.

(d) *Fraenkel's Archiv für Laryngologie*, vol. vii, Dritter Heft.

(a) *Brit. Med. Journ.*, October 26th, 1895, p. 1084.

(b) *Ibid.*, Vol. II, 1903, p. 1124 (Dr. Jobson Horne).



enormous number of cases in which during the last forty years fragments of growth have been intralaryngeally removed for purposes of microscopic examination, this one fact suffices for me, and, I venture to think, will suffice for most men of a practical turn of mind, to dismiss Dr. Mackenzie's alarming assertion as too theoretical to come within the range of practical politics.

Seeing the help that the microscope has so often given me in difficult cases of this kind, I personally have no hesitation in following my great teacher's, the late Professor Traube, principle, that, when one is confronted with two evils one ought to select the smaller. In other words, I am absolutely in favour of microscopic examination whenever this is possible.

But Dr. Mackenzie says, thirdly, that "the method is often inconclusive, misleading, and sometimes practically impossible." Here I must again refer to the "Collective Investigation" and express my regret that our author should have so entirely disregarded the lessons taught therein. Within the limits of this address I cannot enter more fully upon this question. It has been thoroughly threshed out in the "Collective Investigation" and its result has been summarised in the following conclusions:—

3. The first of these is that early total extirpation of the entire organ with its tributary lymphatics and glands, whether the latter be apparently diseased or not, should be performed as the only possible safeguard against local recurrence or metastasis in practically all cases of malignant disease of the larynx as soon as the diagnosis had been established. It is true that in the last part of the paper it is admitted that there may be "exceptional" cases in which a "very small growth, distinctly circumscribed, remote from the middle line, and not of a specially malignant type, may possibly be removed with safety" by extirpation of half of the larynx and the lymphatics on the corresponding side. But even this admission is made grudgingly, and from the whole tenor of the paper and the context of the paragraph in question it is perfectly obvious that operation for cancer of the larynx, to be in the author's opinion complete, ought to embrace nothing less than removal of the whole organ with its lymphatic vessels and glands. This recommendation is based upon the author's contention that the severity of surgical interference, when dealing with cancer, ought to be the same in whatever part of the body a malignant growth may be met with. This contention again shows a profound disregard of practical experience. Whilst no sane person has ever asserted that cancer is one thing in one part of the body and another thing in another, both careful clinical observation and the results of surgical interference have incontestably shown that—other circumstances being equal—both the severity of the required interference and recurrence after operation depend to a degree, the practical importance of which can hardly be over-estimated, upon the question of the primary localisation of the malignant new growth. Every surgeon when called upon to give a prognosis and to operate in a case of epithelioma of the lip, the ear, or the penis, knows that the prognosis with regard to recurrence is infinitely better, the amount of interference required much smaller, than in a case of epithelioma of the tongue or pharynx, or in a case of cancer of the breast. These facts are so fundamental and so generally admitted that I hardly think a single surgeon will be prepared to deny them.

After a full review of the operative side of the question, the lecturer proceeded: From the foregoing observations I trust you will have seen that I am certainly not an extremist, and I may further tell you that, acting upon my views, I have, in the course of the last year alone, myself sent three patients suffering from advanced malignant disease of the larynx, and in whose cases operative interference had been refused by British surgeons, to Professor Gluck. Even the fact that unfortunately two of them have within a few months after operation developed recurrence would not deter me from consenting to, or even advising on, future operation in similar circumstances. But one thing,

gentlemen, I think, is absolutely certain—*i.e.*, that such grave operations ought only to be undertaken under two conditions—(1) that the diagnosis was absolutely certain; and (2) in the event of there being no possibility of saving the patient by a less mutilating operation.

With regard to the first of these conditions it is one of the most surprising omissions in Dr. Mackenzie's paper that he should not have referred by one single word to the terrible situation which would be created for both the patient and the surgeon in the event of so serious an operation as that proposed by him being undertaken on the strength of a mistaken diagnosis.

Four methods here come into consideration—intralaryngeal removal, subhyoid pharyngotomy, thyrotomy, and hemilaryngectomy. With regard to the intralaryngeal method, I have unfortunately had to differ on so many points from Dr. Mackenzie that it gives me genuine pleasure to say that at any rate I am at one with him when he says that "operation for laryngeal cancer through the mouth, done almost universally to-day, it seems to me should no longer come within the range of serious consideration." I reject intralaryngeal operations in cases of laryngeal cancer—which, by the way, I believe to be not nearly so universally practised as Dr. Mackenzie assumes—not because I deny the possibility of curing a few patients by this method, but because, in my opinion, the game is not worth the candle.

The second contingency—subhyoid pharyngotomy—can be dismissed in very few words. Although I have lately heard privately that better results have been obtained more recently, I am waiting for confirmation of these tidings before I see my way to recommend adoption of this method in cancer of the larynx.

4. But how about thyrotomy? Here we come to the last and perhaps the most extraordinary of Dr. Mackenzie's assertions. As already stated, he unreservedly condemns this operation in the following terms: "Thyrotomy with curettement or removal of all apparent (visible) parts diseased is not up-to-date surgery, is in direct defiance to the rules that should govern us in the treatment of cancer, and is a reversion to, and a resurrection of, a method of procedure that was discredited and abandoned half a century ago." I know that Dr. Mackenzie is absolutely incapable of deliberately making a misleading statement, but in speaking of thyrotomy as being not up-to-date surgery, as being in direct defiance of the rules that should govern us in the treatment of cancer, and being a reversion to, and a resurrection of, a method of procedure that was discredited and abandoned over half a century ago, he none the less creates as wrong an impression in the mind of the uninitiated reader as if he had intended to produce it.

In the introduction to this paper I have reminded you that thyrotomy for laryngeal cancer was in 1878 discredited and subsequently practically abandoned because in those days advanced and therefore *a priori* unsuitable cases were subjected to an operation the *technique* of which at that time was anything but methodically developed. If twenty years afterwards, with improved *technique*, that operation has again been resorted to in a class of cases totally different from those in which it has been unsuccessfully employed at a previous period, it surely is not fair to describe a progressive and beneficial development of that character as "a reversion to, and resurrection of, a method of procedure that was discredited and abandoned half a century ago." If during that period its true nature be recognised, and an operation be performed which not merely removes the tumour itself but a sufficient area of healthy tissue in all directions round it, the patient has a reasonable chance of being lastingly cured. Such an operation is modern thyrotomy as first suggested by Mr. Butlin. Fifteen years' experience has shown that by its employment the disease can be completely and lastingly eradicated, and to describe it as an "incomplete and therefore hazardous and unsurgical" operation is wide of the mark.

And now as to the results of the operation so much deprecated by Dr. Mackenzie. Last year at Swansea I

reported from my own practice twenty thyrotomies with or without removal of small fragments of cartilage in cases of undoubtedly malignant disease of the larynx, with nineteen recoveries, two quite doubtful recurrences, and one death. (a) I am now—irrespective of the incomplete operation which had to be repeated—in possession of the notes of twenty thyrotomies performed for undoubted malignant disease of the larynx between 1891 and 1904 with one death, two doubtful recurrences, and seventeen lasting cures, bringing the percentage of successful cases in my own practice within that period up to 85 per cent. In addition to the twenty cases just named, I have performed three further thyrotomies in the course of the present year. All three patients have made an excellent recovery. In one of them, however, in which the patient had, in spite of my urgent advice, unduly postponed the operation, recurrence has, unfortunately, taken place, and I have had to perform partial laryngectomy on the eve of my departure for America. The other two cases are of too recent date to be included as yet in the class of permanently cured cases.

From the foregoing facts it will not surprise you if I most warmly recommend the performance of thyrotomy in suitable cases of intrinsic laryngeal cancer.

Permit me earnestly to repeat my advice that thyrotomy should be performed only when the new growth is still limited to the intrinsic region of the larynx, is still circumscribed, is not too extensive, and does not infiltrate too deeply, and that in such circumstances a sufficient zone of healthy tissue should be included in the area to be removed *everywhere* in sufficient distance from the new growth. Should it be found, in the course of operation in a case which seemed on laryngoscopic examination to fall under this category, that the disease is more extensive than had been presumed from laryngoscopic appearances, the operator must not hesitate to extend his operation into hemilaryngectomy, or if both sides of the larynx should be involved into total extirpation. It is only by the observance of this cardinal rule that thyrotomy will gain the place which is due to it among radical operations for cancer of the larynx.

The second request I have to make is this: Whilst thyrotomy is still on its trial everywhere except in Great Britain, let me ask you to proceed strictly on the lines suggested by Mr. Butlin and myself. I do not believe in the finality of our present *technique*, and I willingly admit that it may be possible, when once thyrotomy has everywhere gained its place among recognised operations for laryngeal cancer, to improve upon the method of operation by means of which we have obtained such satisfactory results. But whilst the operation is still on its trial do not complicate matters by prematurely introducing modifications.

The only remaining operation to be discussed is hemilaryngectomy, or partial extirpation of the larynx. Already last year at Swansea I expressed my conviction that partial extirpation of the larynx will come to be more rarely performed in proportion to the diagnosis of malignant disease being arrived at more and more early, when thyrotomy will suffice. I should not offer any objection to extirpation of the corresponding lymphatic glands even if apparently unaffected in cases of hemilaryngectomy for cancer, although, as my third case shows, even that measure, when once metastasis has actually occurred, does not give the patient a guarantee against recurrence. That such extirpation should, as a matter of duty, be performed in cases of hemilaryngectomy if the glands are in the least shotty or visibly enlarged goes without saying, but in such cases the prognosis anyhow is unfortunately very doubtful.

And now, gentlemen, I am at the end of my task. I have, as promised, nailed my colours to the mast of

(a) I take this opportunity to correct a slip of the pen which I just find is committed in my paper published in Fraenkel's "Archiv" in 1897. It is stated there (p. 419) that I had lost "two" patients from thyrotomy performed by myself. On reference, however, to my original article (*loc. cit.*) it will be seen that one of those cases (Case 6 of the tables) was not one of thyrotomy, but of partial extirpation of the larynx.

practical experience as against theoretical possibilities. At the same time I trust I have succeeded in showing you that the principles upon which my views are based are not purely empirical, and are in all points in concord equally with the experiences of practice and with the achievements of science. Let me summarise what I have endeavoured to establish under the form of the following theses, which may serve as a basis for the discussion which I understand is to follow the reading of this address:—

1. It is of the greatest importance that the diagnosis of laryngeal cancer be made at the earliest possible moment. For this purpose it is most essential that the still prevailing notion—*vis.*, that malignant disease of the larynx is from the first attended by all sorts of grave constitutional symptoms—be completely eradicated and that the attention of the general practitioner should again and again be drawn to the fact that there are no more promising cases for radical operation than those in which the disease is at first manifested by nothing else than by obstinate hoarseness, occurring, without any apparent cause, in middle-aged and elderly persons.

2. Clinical diagnosis arrived at from the history and subjective symptoms of the case, from laryngoscopic examination, from accessory circumstances of importance, such as the patient's age, &c., has reached a certain degree of perfection, and enables us in a good many cases to make a correct diagnosis at an early stage of the disease; it is, however, by no means absolutely perfect, and occasional mistakes occur even in the practice of those most experienced.

3. In these circumstances clinical diagnosis ought, whenever possible, to be confirmed before radical operation of any kind is undertaken, by the intralaryngeal removal and microscopic examination of a fragment or fragments of the new growth. This, however, should only be done if the patient previously consents to immediate radical operation being undertaken in the event of the microscope confirming the clinical diagnosis. Should this be the case, the practitioner's position will have been materially strengthened. The microscope, however, is by no means infallible in these cases. Should its evidence be negative or inconclusive the intralaryngeal removal and microscopic examination of fragments should either be repeated, if necessary, several times, or, if the clinical symptoms do not warrant postponement, exploratory thyrotomy should be undertaken.

4. The intralaryngeal method is from its very nature unsuitable for the radical removal of malignant new growths of the larynx.

5. Subhyoid pharyngotomy, apart from being applicable in a very small number of cases only of malignant disease of the larynx, is still *sub judice* with regard to its advisability in such cases.

6. Thyrotomy, if undertaken in suitable cases, and at a sufficiently early period, and if performed on the modern lines which experience has shown to be successful, is a perfectly ideal operation in intrinsic cancer of the larynx.

7. Hemilaryngectomy comes into question only when it is found after opening the larynx that mere thyrotomy will not suffice. When performed it may be accompanied by removal of the tributary lymphatics, even if apparently not diseased.

8. Total laryngectomy should be exclusively reserved for extrinsic, and for those cases of intrinsic cancer in which both sides of the organ are affected, and in which the disease has proceeded too far to be eradicated by milder measures. When performed it should be accompanied by the removal of the laryngeal lymphatics on both sides of the neck.

If the adoption of these principles should meet with your approval, gentlemen, there will be an end to the deplorable schism which has of late separated the surgeons and laryngologists of various countries with respect to the diagnosis and treatment of malignant disease of the larynx, and we may justly hope that in striving shoulder to shoulder we shall advance science and benefit our patients.

## A HELPFUL AGENT IN THE TREATMENT OF SURGICAL DEBILITY.

By J. S. PURDY, M.B., C.M.Aberd., D.P.H.Camb.,  
Of London.

THE condition of depression or exhaustion occurring in surgical patients is so common and oftentimes so rebellious to treatment that any measure which seems to offer material help in that direction is welcomed eagerly by surgeons generally. Many surgical cases manifesting obvious and striking signs of impoverishment of blood, nutrition, or nervous force owe their origin and continuance to one or more conditions amenable to operative procedures only. Equally true is it that perhaps even a larger number of cases do not regain their normal standards of health with satisfying rapidity after operations, or are in a debilitated state which necessitates postponement of operations, and it is in these cases that surgeons are compelled to seek the aid of tonic and reconstructive drugs.

The object of this communication is to record, briefly, general and specific observations upon this point made during the past two years in the surgical wards and out-patient departments of two large metropolitan hospitals, where cases are sufficiently numerous and facilities ample to obtain valuable clinical data upon the subject. In the management of these cases, so many extraneous and contributing factors enter that it is sometimes difficult to determine how much of the benefit is due to the medicines administered, and how much must be attributed to hygienic measures, suitable dieting, careful nursing, &c. Nevertheless, these factors are more or less constantly present, and, with the added guidance of experience, one is enabled to form fairly accurate deductions as to the rôle played by drugs in the sum total of general improvement. These points have been given due consideration, and after two years' comparisons of various tonics and reconstructives in pre- and post-operative surgical conditions we believe we are justified in stating that iron vitellin must be considered as a valuable aid in the treatment of what may be termed surgical debility. British physicians are proverbially conservative in accepting innovations in any phase of practice, and particularly in the matters of new drugs and new operations; perhaps such new departures are scrutinised with more care in this country than elsewhere, and we are not given to accepting the statements of others without personal verification. In this connection, it is interesting to note that several of the most distinguished and conservative British physicians—Murrell, Phillips, Tirard, Carpenter and others—have published careful scientific studies of iron vitellin which substantiate that this drug has physiological effects of a nature which endow it with unique value in certain clinical conditions. Our observations corroborate those already published, although ours were confined almost entirely to cases of a surgical nature.

The cases in which we have administered iron in this form may be divided into four general groups:—

1. Surgical convalescence.
2. Anæmia from hæmorrhage.
3. Preliminary to operations of a more or less serious character.
4. In the class of out-patients suffering from immediate or remote effects of syphilis, tuberculosis, osseous necrosis, &c.

The points about the clinical effects of iron vitellin which seem to be worthy of emphasis are illustrated best by brief notes of cases in which much of the improvement noted was clearly ascribable to the action of the remedy.

A robust woman, æt. 23, presented herself with an acute and especially virulent attack of gonorrhœa, involving the entire genito-urinary tract, including the uterus. Disobedience of house rules as to rest and

local treatment led in ten days to the development of chills, fever and delirium. Examination revealed signs of double pyosalpinx, which demanded immediate operation. She was curetted, the uterus packed, abdominal cavity opened and both pus tubes removed. Pelvic peritonitis rather diffuse was present. Her condition was grave and for the ensuing five days, with a temperature of 104°, and pronounced symptoms of sepsis, her recovery was considered doubtful. On the sixth day after operation, her temperature began to fall, and on the tenth day had reached normal. The toxæmia seemed to have ravaged the blood particularly. Her lips and conjunctivæ were colourless, the skin waxy-green, prostration very marked. Hæmoglobin was 20 per cent., red blood corpuscles 1,700,000. Stomach intolerant of food and medicines. She was given koumiss, broths, as much as she liked, and iron vitellin in tablespoonful doses, three times daily. One week later, hæmoglobin was 45 per cent., red blood corpuscles, 3,000,000. Two weeks later hæmoglobin 52 per cent., red blood corpuscles, 3,200,000. Three weeks later hæmoglobin 65 per cent., red blood corpuscles, 3,700,000; colour, strength, appetite, digestive power, all strikingly improved. Five weeks after the operation, and two days before she left the hospital, her hæmoglobin was 87 per cent., red blood corpuscles, 4,200,000. The rapidity of the action of iron vitellin in restoring the blood constituents in this case was probably due to the condition known as "iron hunger," brought about by the rapid destruction of the blood elements by the toxins.

Toxic anæmia similar to the case just cited is by no means uncommon, and occurs in practically all cases where the systemic infection has been at all marked. The difficulty in treating these patients with food and medicine directed to restoring the wasted tissues is increased by an irritable, non-retentive condition of the stomach. In all of the cases treated thus far with iron vitellin in no instance has the remedy been rejected, nor has it ever induced signs of irritation of the stomach or intestines. We have been very much struck with this fact in the post-operative treatment of four cases of septicæmia in which gastric irritability was most marked. Two of these cases were sepsis following criminal abortion, one case of pyothorax, and one large superficial abscess of the liver, in all of which operations were performed; systemic infection followed with consequent toxic anæmia, and in which iron vitellin was used successfully in combating the anæmia and adynamia.

We have made observations also of the effect of the remedy upon the blood in twelve cases of severe exsanguination as the result of accidental hæmorrhage. Eight of these occurred during labour, four of which were cases of placenta prævia; the remaining four cases were the result of severe arterial hæmorrhage in consequence of lacerated wounds. Of the total of twelve cases, in ten of them iron vitellin restored the blood constituents to normal in periods varying from two to five weeks; in two cases, both debilitated women, the blood constituents remained below the normal standard after six weeks' treatment.

Surgical debility, so called, is a rather complicated pathological condition in which anæmia is entirely subsidiary to very obvious disturbance of general nutrition. In this class of cases tonic and reconstructive drugs are employed, as a matter of routine, with widely-varying degrees of success. No one drug or combination of classes of drugs prove uniformly efficient, and the choice of remedies is usually decided by a consideration of the individual indications, not the least of which is the condition of the gastro-intestinal tract. From our observations, extending over a period of two years, we believe that iron vitellin gives perhaps the best percentage of good results as a remedial factor in the general hygienic measures applied in the treatment of surgical debility. The following is a case in point:—

A woman, æt. 27, married, had recurrent attacks of appendicitis of moderate severity, extending over a

period of three years. She had also prolapsed ovary, adherent tube on right side, dysmenorrhœa. For two years she had steadily failed in general health and had lost 20 lbs. in weight. She was operated on in January, 1903, the enlarged, inflamed appendix, the right tube and ovary, removed. Recovery from the operation was uncomplicated, but the patient remained pallid, weak, nervous and irritable, had anorexia, nausea and vomiting. Five weeks after the operation, when the above symptoms were present, she was placed on a partial rest-cure régime, was given massage, electricity, careful diet, and a tablespoonful of iron vitellin three times daily. At that time her hæmoglobin was 55 per cent., red corpuscles, 3,000,000. Under the combined therapeutic measures applied, she gradually gained in strength and flesh, her stomach became receptive and retentive, and the nervous irritability disappeared. Four weeks later she had gained 10 lbs. in weight, had no troublesome symptoms, hæmoglobin was 80 per cent. and red corpuscles 4,300,000, and she was given permission gradually to resume her wonted occupations.

The following case, belonging to a different category, is illustrative of another type of cases in which we have used the remedy to obvious advantage:—

A man, æt. 61, plethoric, considerably adipose, had been under treatment for two years for prostatic enlargement, with retention of urine and gradually increasing attacks of cystitis. For two years his general health had failed, and for six months it was deemed necessary to operate, but pallor, lassitude, inability to take sufficient nourishment, and presence of chronic dyspepsia, and red blood corpuscles 2,550,000, hæmoglobin 55 per cent., indicated too great general disturbance. He was sent to Aix-les-Bains in May, 1903, where his dyspepsia yielded satisfactorily to the régime practised. The only tonic used was iron vitellin, a tablespoonful in water after meals and at bed-time. After five weeks' stay at the baths his general condition has become remarkably improved, and he returned home on June 15th, when his hæmoglobin showed 82 per cent., red blood corpuscles, 4,550,000. On June 22nd, the Bottini operation was performed, and the patient made a satisfactory recovery, and is at present in excellent health.

Our observations upon the use of iron vitellin among surgical out-patients are chiefly of value in determining its general tonic action rather than specific effects upon the blood, as with but few exceptions systematic blood examinations were either impossible or deemed unnecessary. In syphilitic patients, of the secondary and tertiary stages, we were able to confirm the statements already published, that iron vitellin is a valuable adjunct to antisyphilitic treatment, in that it has a beneficial action upon the anæmia so constantly present, and improves the general nutrition, which is usually below par. These effects were noted in the anæmia accompanying the eruption of secondary syphilis and in the anæmia and malnutrition of the gummata and necrosis of the tertiary stage.

This general tonic action of the remedy is perhaps its chief claim for consideration, and is the first effect to strike the attention of both the surgeon and the patient. It is particularly noticeable in the management of tuberculosis of the glands, bones and joints when the remedy is administered conjointly with appropriate surgical treatment, and judicious application of such valuable aids as good food, &c.

Another class of surgical out-patients in which we have used iron vitellin with conspicuous success is illustrated by the following brief notes:—A nurse had become very much run down in consequence of a whitlow and onychia, the thumb-nail having been removed. She was given iron vitellin, a tablespoonful three times daily. Her appetite improved, pallor gradually disappeared, there was no constipation, and she rapidly regained health and strength.

Another case was that of a man who was very much debilitated and was suffering from repeated crops of boils. Arsenic and calcium sulphide were given without appreciable effect. A fortnight's treatment with

iron vitellin effected a striking improvement in the general health with coincident disappearance of the boils.

This communication must be looked upon as a purely clinical one, with no ambition to deal with the scientific phases of the questions involved in a study of the broad problems of anæmia and malnutrition, whether they be of surgical or medical cases.

These questions properly fall within the sphere of the hæmatologist, the physiological chemist, and the physician. It seems, however, to the practical surgeon that in dealing with these conditions the pure scientist is too prone to unduly emphasise one feature—for instance, systematic blood examinations—when called upon to determine the effect of any given plan of tonic treatment, medicinal or physical. Far more important is it in forming such opinions to consider the effect upon the blood constituents as but a subsidiary feature, and to give due weight to the effect of treatment upon the appetite, the ability to digest and assimilate food, and upon the general nutrition as revealed to the physician by a glance or by inquiry, unassisted by the precise methods of investigation, such as blood examinations. In other words, the practical value of such treatment is in proportion as it produces visible improvement in the general condition of the patient.

### CLINICAL NOTE ON MEDITERRANEAN FEVER.

By CHARLES HELFIELD, M.A., M.B., M.S.

HAVING taken some interest in the etiology and pathology of Mediterranean fever, and having had the opportunity of living on the coasts of the Mediterranean, I watched all cases of fever that fell to my *confrères* and my lot to treat as attendant or consultant; I therefore beg to offer a word to its effect.

Out of perhaps 300 cases attended by us I discovered that the micrococcus melitensis of Bruce was not only conveyed by the air, but it was capable of being introduced into the system by food and drink. Bacteriological examinations corroborated our suspicions in finding the bacilli in water kept in jug or filter from which the patient under our care had drank before he or she complained of any symptoms—*i.e.*, headache, giddiness, vomiting, or a profuse perspiration, and in six cases out of ten the micrococcus could be found in fresh fruits, such as figs and prickly pears (*opuntia*). This same disease, though endemic in Egypt and the Red Sea, appears under different aspects, forms, symptoms, and course, and cannot in any way be compared to those occurring at Malta, Naples, Tunis, and Sicilian ports. At Malta the variety generally seen can be easily diagnosed by the splenic enlargement, its relapses, constipation; and the temperature reaches up to 104°. but generally it is undulatory and always with profuse sweating; the first symptom is diarrhœa. Delirium is very often present during the first fortnight's illness, and the patient feels very irritable. The complications are arthritis, tenderness over the spleen and liver, neuralgia, and, in rare instances, orchitis. In Sicily the variety is similar to that of Malta fever, but it tends to be more malignant in its type; the onset is sudden and the mortality is nearly 5 per cent. In Egypt or at the Red Sea ports, the variety is intermittent, of a short duration—five weeks the utmost—the symptoms are those of ordinary pyrexia and the mortality is 0.5 per cent.

What I desire to illustrate is the urgency of obtaining the reaction in every case of fever that

falls to the practitioner's lot, just to ascertain the quality of the fever; the reaction can be had in all varieties, and in every case on the fourth day. As for the treatment, rest is essential; the patient must get at short intervals plenty of nutritious fluid diet, the skin should be sponged at least four times a day with brandy or whisky and water, no alcohol should be given internally unless urgently required, and the drug that proved with us most beneficent and curative was kaïrin in 5-grain doses, with 3 of oleum eucalypti three times a day, with a hypodermic injection of strychnine, 1-50, once a day. Quinine is hurtful, and other drugs and intestinal disinfectants useless; constipation must be treated with an enema of castor oil and warm water daily.

Mediterranean fever seldom attacks people living in the country, or the lower classes, and when it does it is of a very short duration, but it is most liable to attack the better classes, town people and those in busy life.

### A NEW UTERINE MOP.

By S. JERVOIS AARONS, M.D., M.R.C.P.

THE difficulty and amount of time wasted in removing the wool from the ordinary Playfair's probe after it has been used led me to try and devise some means by which the mop might be more easily and quickly removed. It occurred to me that a cap of some absorbent material which would fit over a conical probe would serve the purpose, and such a cap, or mop, I have had made; this slips over a conical or tapering metal probe, and is held in position by a small bayonet catch, which effectually prevents it from twisting round or leaving the probe.

The dry mops weigh 13 grains (.79 grammes); after being used they weighed 39 grains (2.5 grammes); they are therefore sufficiently absorbent for the purpose.

The advantages over the ordinary Playfair's probe are:—

1. Ease and rapidity of dressing the probe.
2. Ease and rapidity of removing the mop after use.
3. Both mops and probes are easily sterilised.
4. The tapered part of the probe, being made of plated copper, can be bent to any desired shape.

The caps are put up in sterilised packets of four, or they may be had separately but not sterilised.

Both probe and caps were made for me by the Galen Manufacturing Co., Ltd., Wilson Street, New Cross Road, S.E., and my thanks are due to them for so successfully carrying out my suggestions.

#### The Cancer Hospital, Brompton.

WE are asked to announce that Lady Ludlow has kindly promised to open the new nurses' home erected in the hospital grounds on November 14th, at 3 p.m. The nurses at present are accommodated at the top of the hospital building in cubicles. The new home will provide separate bedrooms for each nurse, and a separate sitting-room for the sisters and nurses. The cost of erecting and equipping the home is about £5,500, but the committee feel that the expenditure is justifiable bearing in mind the arduous duties nurses at such a special hospital have to perform.

## Out-Patient Departments.

### TOTTENHAM HOSPITAL.

*Dermatological Cases under the Care of G. NORMAN MEACHEN, M.D., M.R.C.P.*

CASE I.—*Tar-Acne in a Psoriatic.*—The patient was a young man, æt. 19, an ex-postman, who said he had suffered from psoriasis since early childhood. He did not seek advice so much for this complaint as for a troublesome eruption around his shoulders. The history was that he consulted a chemist upon his own account a year ago for his chronic skin disease, and obtained from him some crude tar ointment, which he had been vigorously rubbing into the skin of his back. From previous experience he had learned that tar was "good for psoriasis." His grandmother had suffered from the same affection, but no other members of the family were affected. There was no history of rheumatic fever. His general health was good.

On examination, several typical lesions of psoriasis, in varying stages of evolution, were seen upon the trunk and limbs, but the most noticeable thing was a profuse papulo-pustular eruption about the shoulders and interscapular region. Interspersed between the papules were a large number of comedones. The face was clear, but there were several scaly places in the scalp.

Dr. Meachen remarked that acne-like eruptions were not infrequently seen in those who worked with tar and pitch, but it was not at all common to meet with true acne picealis as a result of tar medication in psoriasis. The application of the old-fashioned pitch plaster sometimes led to erythema and even to dermatitis, owing to the continuous local action of a mild irritant. This youth had been applying tar ointment daily for a twelvemonth without any medical advice under the impression, which was a very common one, that the more energetically he rubbed in the medicament the quicker he would be cured. It might, perhaps, be questioned why the acne should only have appeared upon the shoulders and not upon the limbs or other parts of the body, for he had applied the ointment everywhere. It must be remembered, however, that the severest cases of acne were often seen upon the back and interscapular region, these parts, together with the face, being the seat of election for the disease. Pathologically speaking, the lesions were produced through a blocking of the sebaceous ducts with tar, the presence of which acted as a local irritant, leading to inflammatory changes within the follicles and dilated portions of the ducts. Furunculosis was also seen as a result of the external application of tar.

A weak sulphur lotion was prescribed for the back together with the compound sulphur ointment, while a mild creolin ointment was ordered for the scaly patches upon the limbs. For the scalp the ung. hydrarg. ammon. was prescribed.

CASE II.—*Canities following Alopecia Areata.*—A little girl, æt. 8, was brought with several large patches of white hair upon the scalp. A year previously she had been treated for alopecia areata, but she had ceased to attend the out-patient department for some months. Shortly before the hair fell out she had an attack of scarlet fever, during which time the mother said the hair was not cut off. She had had no other illnesses.

On inspection the child presented a remarkable appearance, nearly one-quarter of the left side of the scalp being covered with silvery white locks. The adjacent hair was dark brown in colour. The eyebrows and eyelashes were normal. The general health was good, though the child was of an excitable disposition.

Dr. Meachen pointed out that the growth of hair which occurred upon an alopecic patch was generally of a somewhat paler tint than that which was lost, but it was distinctly uncommon for actual grey hair to appear, especially in a young child. The appearance

of the well-known downy growth upon the previously smooth and billiard ball-like area was always a most hopeful sign, and with the progress of time pigment began to be deposited within the hair shafts. The whole question of the production of pigment was rather complicated, since its visibility depended not only upon its absolute quantity, but also upon the degree in which air-bubbles were present between the cells of the cortical layers. A return to the natural colour was exceedingly rare, though cases had been recorded of such a transition.

As regards treatment, extensive canities might, in many cases, justify the systematic use of hair dyes. This little girl did not like going to school because the other children made fun of her. Silver nitrate in plain solutions of 1 to 3 per cent. was, on the whole, the best reagent for this purpose, though corrosive sublimate and pyrogallol were also largely employed. The parents of the child were strongly impressed with the idea that if the hair had been entirely shaved off during the attack of fever it would have come back the natural colour! There was a semblance of truth in this supposition, but clinical evidence was insufficient to enable us to state definitely one way or the other.

### British Health Resorts.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]

#### XV.—TORQUAY.

TORQUAY has won high repute as a health resort, and rightly holds a foremost place among winter stations. It is situated in a bay on the north side of Tor Bay, and has a south exposure. Its physical features are widely diversified and well fit it as a natural sanatorium. Comfortable shelter is afforded by the hills of the Torquay promontory, which rise to 448 feet. The geological formation is mainly Middle Devonian limestone and Lower Devonian grits and slates, and there is very little clay, and what does occur is of the nature of marl. Careful meteorological observations are taken twice daily at the Borough Station, which is admirably equipped with modern instruments of precision. [We are indebted to Dr. Thomas Dunlop, M.O.H. for Torquay, for a copy of his Annual Report for 1903, and much other information of service.] Mr. Frederick Marsh is the official meteorologist. The mean barometric reading for last year was 29.935. The temperature figures testify to the equability of the climate. The maximum mean was 56.7°; the minimum mean, 47.1°; the maximum and minimum mean, 51.9°; and the mean range, 9.6°. The duration of bright sunshine as recorded by the Jordan photographic twin instrument was 1,645.1 hours, and as recorded by the Campbell-Stokes standard instrument, 1,699.6 hours. The total rainfall amounted to 41.15, which was much above the average of recent years. The mean humidity was 78, as taken by Mason's hygrometer. During the latter part of the year west winds prevail, but in the spring the winds are chiefly easterly. The population is 33,810, the birth-rate, 15.8 per 1,000, and the gross death-rate 13.4 per 1,000; but on eliminating the deaths of visitors it comes out at 11.5 per 1,000. The water-supply, which is abundant and constant, is derived from upland surface gathering ground about fifteen miles from Torquay on the borders of Dartmoor. The water contains a small amount of lime and magnesia. The drainage system has been well designed and is maintained in a thoroughly efficient manner.

Torquay is admirably supplied with means for outdoor recreation, the public pleasure grounds and gardens, roads and foot-paths, are peculiarly well fitted for the needs of the health-seeker, whilst the immediate neighbourhood offers endless attractions as a centre for charming excursions. There is, however, a lack of those attractions under cover which are so sedulously catered for at Continental health resorts during the winter months, the absence of which at

Torquay is considered a serious drawback to those in search of amusement as well as health.

There are many excellent hotels and boarding-houses, and suitable apartments may always be obtained; but Torquay is in great measure a residential haven for the aged, and those invalided or injured in life's conflict.

Torquay is an admirable winter resort for those who, while enfeebled and unable to stand the exposure of most of our British stations, need a home residence with open-air life. The aged here find the burden of advanced life much lightened. The constitutionally delicate and those invalided by actual disease are afforded shelter and can maintain a hygienic life in comfort and carry on some form of work with pleasure and profit. Torquay is a very desirable winter centre for convalescents.

For many cases of pulmonary disease it provides conditions particularly alleviative. While it is undesirable for most incipient cases of phthisis it is well fitted for many chronic and advanced cases, particularly where the bronchitis involvement is conspicuous.

For elderly persons, the subjects of chronic bronchitis, emphysema, asthma, renal disease, and those requiring a comparatively warm, sheltered, equable climate, with opportunities for gentle exercise and quiet amusement, Torquay may be strongly recommended.

The hillsides are, of course, unsuited to many cardiac cases and subjects of vascular deterioration. For neurasthenics and those suffering from some forms of nervous derangement, Torquay during winter days can offer much that is desirable.

### Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.  
SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, OCTOBER 28TH, 1904.

H. C. EARL, M.D., in the Chair.

#### LYMPHATIC LEUKÆMIA.

PROFESSOR E. J. McWEENEY, M.D., read a paper entitled "Hæmatological Observations on a Case of Chronic and one of Acute Lymphatic Leukæmia." The first case was that of a man, æt. 55, admitted to the Mater Misericordiæ Hospital on September 2nd, suffering from splenic tumour, glandular enlargement and asthma. The most remarkable point in the previous history was an injury to left side of the abdomen, sustained last January, after which a sensation of discomfort developed—a possible traumatic origin being thus suggested. The cervical glands began to enlarge about Easter; the splenic tumour was first noticed in May. Blood-count on admission: R., 3,908,000; W., 163,000. Two days later the count was R., 2,848,000; W., 206,000. The differential count yielded polymorphs, 7.8; large mononuclears, 2.3; lymphocytes, 89.5; eosinophile and mast cells, 0 per cent.; a few normoblasts. On September 25th he developed lobar pneumonia, to which he succumbed on the 28th. There was no diminution of the total leucocyte-count consequent on the infection, and no increase of polynuclear elements in the peripheral blood on the day preceding death. The count on that day was R., 3,048,000; W., 332,000; percentage of mononuclears, 92.4. On the other hand, the blood taken from the lung at the autopsy twelve hours after post-mortem yielded 20.5 per cent. of polynuclears, as well as 0.5 per cent. of eosinophiles, and 3.5 per cent. of myelocytes, neither of which could be found in the peripheral blood during life. The spleen weighed 51 oz., was marbled with red and grey patches, and contained infarcts. Microscopically the trabecular system was much reduced, and the follicles obliterated by a uniform distribution of rather large mononuclear elements. Mitoses were hard to find; there was much iron-containing pigment; no giant cells. The glands were all much enlarged, highly vascular, distinction between follicles and sinus obliterated; mitoses



numerous. The marrow of the femur and humerus was of the normal character; that of the sternum was lymphoid. The liver (283 ozs.), kidneys and suprarenals showed typical lymphoid infiltration. The absence of blood change consequent on pneumococcal infection and the absence of the marrow change were the two most interesting features of the case.

*Case 2.—Acute Lymphatic Leukæmia.*—Patient was a boy, æt. 9; six weeks ill on admission, with moderate fever (100° to 101°); swollen glands, epistaxis and great prostration. The spleen was moderately enlarged, as was also the liver. Petechiæ on skin of abdomen and legs. Blood-count on admission: R., 1,898,000; W., 212,000; lymphocytes, large and small, being 98 per cent., with only 0.5 per cent. of polymorphs. Many of the lymphocytes showed signs of degeneration. On puncturing the skin through a droplet of Unna's polychrome methylene blue, their nuclei took the stain at once. No hard and fast line of separation could be drawn between small and large forms; the latter were very labile. Eosinophile and mast cells absent; normoblasts in small numbers, megaloblasts absent. The case ran a rapid course, dying nineteen days after admission from the uncomplicated disease. Blood-count on day of death was, R., 820,000; W., 723,000, 99.5 per cent. of which were lymphocytes. Several fields had to be searched before a polymorph was encountered. At the autopsy (three hours after post-mortem) the heart was distended with puriform blood. Thymus much enlarged; weighed 46 grammes. All the serous membranes covered with petechiæ. All the glands were moderately enlarged, soft and hyperæmic, but not confluent. Spleen (12 oz.) seemed almost normal save for the enlargement. Liver enlarged with enormous leukæmic infiltrations, the intralobular capillaries being literally plugged with lymphocytes. The kidneys were also most extensively infiltrated, and presented a very peculiar appearance. The lymphoid structures of the intestine were enlarged. The marrow of femur and tibia was hyperæmic and typically lymphoid (splenoid of Ziegler). It consisted almost entirely of large peculiarly lentish lymphocytes. Normoblasts frequent, megaloblasts few. Coarsely granular cells absent. The blood was examined bacteriologically ten days previous to death, 5 c.c. being withdrawn from a vein near the elbow and placed in a flask containing 500 c.c. of ordinary peptone broth, and incubated. No growth occurred, and after four days the blood cells seemed unaltered in the sediment. No trace of protozoa. This case afforded a highly favourable opportunity for the study of acute lymphæmia, as the autopsy was complete, and the tissues were fixed within five hours of death. The paper was illustrated by numerous microscopic preparations and coloured drawings, as well as by the specimens preserved at the autopsy.

PROFESSOR WHITE said that during the past year he had seen a case of the so-called spleno-medullary leukæmia in which there was apparently a direct connection between an injury and the disease. The patient fell down the hold of a ship, and hurt himself about the abdomen, but was able to work on for a fortnight, after which he went into hospital, and died in a few weeks of leukæmia. Another point in Professor McWeeney's case was the fact that the patient died so quickly of pneumonia. In one of the cases of leukæmia (common variety) he had seen, the patient, a woman, left hospital to go home, but missed her train and had to come back; she almost immediately developed a sharp attack of erysipelas, and died in twenty or thirty hours, showing the little resistance these patients have against infectious diseases. With regard to Hodgkin's disease, he did not think it was typical to find giant cells, and believed that when giant cells were found, we were probably dealing with some chronic infection, possibly tuberculous, instead of Hodgkin's disease.

Dr. CRAIG said that Professor McWeeney's cases rather upset the ordinary clinical teaching; for instance, he had been accustomed to teach that the increase of leucocytes was not so great in lymphatic as

in spleno-medullary leukæmia, but Professor McWeeney had said that in the acute case, at least, the red and white corpuscles were almost equal in number. Another point was that myelocytes were never present in lymphatic leukæmia. With regard to the case of acute leukæmia, he said it was of special interest because occasionally this disease occurs among children, and when the enlarged glands appear, they are supposed to have acute general tuberculosis.

Dr. EARL agreed with Dr. McWeeney as to the presence of giant cells in Hodgkin's disease, and he was certain that in the two or three cases of real Hodgkin's disease which he had examined he had found glands which were not those of tuberculosis.

Dr. McWEENEY, in replying, said that Professor White's observation as to the traumatic origin of a case of the spleno-medullary variety was very interesting, especially the short duration. The case would appear to have been acute myelæmia, which is very rare, whereas lymphæmia is sometimes acute, but he was not certain that any acute spleno-medullary cases had been recorded. With regard to his statement about the presence of giant cells in Hodgkin's disease, he based it on a report of the pathologist of the Ayer Pathological Laboratory, who had examined fifteen cases of the disease, and had met giant cells which it was easily seen were not tuberculous. They arose from some irritation of the large endothelial plates in lymphatic glands. In Germany Hodgkin's disease is called pseudo-leukæmia, as the patient looks as if he is going to have it. If the same cause produced Hodgkin's disease as produced leukæmia, then you would expect to find giant cells in the glands; but you do not. The explanation sometimes given is that in Hodgkin's disease, owing to some peculiarity of the capsule of the gland the greatly increased lymphoid cells in it and in the sides of the gland are so pressed on that they cannot get cut into the blood; whereas, if the same stimulus attacks a gland with soft sides, &c., the new lymphocytes do get out, causing leukæmia. With regard to Dr. Craig's remarks, he said it was very hard to stick to both the pathological and clinical aspects, but there could be no doubt that there are many cases of lymphatic leukæmia which give very large counts. Myelocytes were always present in lymphatic leukæmia, but they wanted looking for.

#### AORTIC ANEURYSM PERFORATING THE OESOPHAGUS.

Dr. MATSON showed a specimen of the above taken from a woman, æt. 50. History of alcoholism, but none of syphilis. Patient had been subject to attacks of rheumatic fever. Two years ago she had an attack of bronchitis, in which she expectorated a good deal of blood.

Dr. TRAVERS-SMITH asked, did the patient vomit blood?

Dr. CRAIG said that during the past year he had seen two cases. The first was a man complaining of symptoms referred to the stomach. He left hospital and came back in a dying condition with an aneurysm which ruptured into the oesophagus. The second case was one which he had met with seven years ago, and six years ago he read a paper stating that this patient with an aneurysm of the innominate artery had been cured. He then went about in good health, having only some dulness at the right of sternum and at the inner end of the right clavicle. During April of the present year this gentleman died suddenly in bed, and the post-mortem report showed that an innominate aneurysm was present. It was the size of an apple, and had walls an inch thick. The dilated portion still contained some blood in the centre. It was solid outside, and was adherent to the sternum, which it had half eaten through. In the descending part of the arch of the aorta was an aneurysm the size of a child's head. It had burst into the oesophagus, the latter, with the stomach, being full of blood. This patient had been cured of the innominate aneurysm, had gone about for seven years, and had grown fat and lived a healthy open-air life, but how long the second aneurysm existed was not known. This case was of interest from the sequel.

Dr. MATSON said, in reply, his patient vomited a considerable amount of blood, and there was a good deal of blood in her stomach.

**AORTIC ANEURYSM RUPTURING INTO PLEURA.**

Dr. GILLMAN MOORHEAD exhibited a case of aneurysm of the aortic arch, which had ruptured into the pleura. The specimen was obtained from a man, *æt.* 35, by occupation a sailor, and who had contracted syphilis ten years previously. The only symptom complained of was that of cough. Rupture occurred suddenly during sleep after the patient had been under treatment for four days. Almost the entire wall of the sac was necrotic, brittle and very thin, and only a small amount of soft clot was present. One hundred ounces of blood were found in the left pleural cavity. The curious point about the case was that rupture had not occurred while the patient was at work, as he had been up to within a week of his death.

**SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.  
MEETING HELD OCTOBER 27TH, 1904.**

The President, Dr. ARTHUR HALL, in the Chair.

Mr. PYE-SMITH showed the following cases and specimens:—(1) Large gall-stone removed on September 6th from the common duct of a woman, *æt.* 50, where it had become impacted subsequent to the removal, two and a half years before, of thirty-six stones from the gall-bladder, which was suppurating. The duct was sewed, a gauze drain being left in contact with it. No bile escaped, and the case did well. (2) Eight faceted gall-stones removed, on September 7th, from the common and hepatic ducts of a man, *æt.* 46, who had had severe jaundice for nine months. Six of the calculi were at the lower end of the common duct and two in the hepatic duct. They were all extracted by an opening at the level of the top of the duodenum. The duct could not be easily sutured and was drained through a stab wound, which closed in a month. The patient did well, but was not yet quite free from jaundice. (3) A fine, spiked, mulberry calculus, weighing 670 grains, removed, on September 20th, by suprapubic lithotomy from a man, *æt.* 28. (4) A small sequestrum of bone, about  $\frac{1}{8}$  inch in diameter, and a silkworm-gut suture, both of which were encapsuled in firm scar-tissue, removed on October 18th from the end of the stump of the forearm of a man, *æt.* 36, who had been shot in the hand two years previously. Immediate amputation had been performed (in Worcestershire), and the wound healed in six months, after two small pieces of bone had come away. The stump continued to be painful and tender, though the skin was in good condition. Two tender spots were found over two small hard lumps. After their excision the pain and tenderness disappeared.

Dr. SINCLAIR WHITE showed the following cases:—(1) A girl, *æt.* 7, with congenital double dislocation of the hip, on whom he proposed to operate by the open method. (2) A man, *æt.* 25, whose right upper extremity had been removed for a round-celled sarcoma of the upper arm by Berger's inter-scapular-thoracic amputation. The patient had made a rapid recovery. (3) A man, *æt.* 46, whose right scapula had been removed in March, 1900, for sarcoma. There had been no recurrence of the growth. He had a very useful arm, but was unable to elevate the upper arm beyond an angle of 45 degrees. In a more recent case still, better movements had been obtained by uniting the trapezius and levator anguli scapulae to the deltoid and the serratus magnus to the rhomboid muscles. The PRESIDENT showed cases of (1) aphasia, (2) Spinal progressive muscular atrophy, (3) multiple naevi of the face.

Dr. D. BURGESS read notes of a fatal case of cardiac hypoplasia in a young woman, and showed a child with intention tremors.

Mr. R. FAVELL showed (1) a specimen of the RUPTURED TUBAL GESTATION, together with an adherent vermiform appendix. The

patient, a married woman, *æt.* 32, married five years, never pregnant, regular twenty-eight days, lasting four days. The last period first week in April. Second week in May began to have a coloured discharge accompanied with frequent attacks of pain. The bloody discharge continued for three weeks, then for a week it ceased, coming on again and then continuing to the time of operation. By the vagina: A tense cystic swelling was felt in right lateral fornix, the uterus pushed over to the left. Section was done on July 1st, three months after her last period. The right tube was greatly distended with organised blood-clot, the embryo being found in the upper part of tube. The tube was ultimately adherent to the parietal and pelvic peritoneum, the vermiform appendix was inflamed and much thickened, being intimately adherent in its whole length to the tube. This was removed with tube.

**(2) DERMOID CYST OF OVARY ADHERENT TO VERMIFORM APPENDIX.**

The patient, *æt.* 32, two children, youngest *æt.* 8, had noticed swelling in lower abdomen for twelve months. Six weeks before operation she was seized suddenly with acute pain across the hypogastric region, accompanied with sickness and faintness. The swelling lay right across the hypogastrium, rising two and a half inches down the pubis. By the vagina: The tumour was found lying in front of the uterus and evidently adherent. On section, the dermoid was found to intimately adhere to the parietal peritoneum, to the uterus, the small intestine, and to the vermiform appendix; great difficulty was found in separating the adhesions. The patient made a good recovery.

**Dr. D. GRAY NEWTON read notes of a case of a GALL-STONE PRODUCING ACUTE INTESTINAL OBSTRUCTION.**

successfully removed by abdominal section, and showed specimen. The patient, a woman, *æt.* 66, eight years ago had her first attack of biliary colic, and then was free except for some dyspeptic symptoms till last year, when she had another attack, this time accompanied by jaundice which passed off in a week or so. The present attack occurred in May of this year, which was relieved somewhat by small and frequent doses of morphia, but early one morning (4 a.m.) she experienced an extra severe attack of pain, which did not last long, and afterwards the patient expressed herself as being more free from pain than she had done since the attack began. This will be seen to coincide in all probability to the passage of the gall-stone from the gall-bladder into the duodenum. Later on in the day she began to be sick, and unable to retain anything in her stomach, the vomit becoming faecal. After consultation with Dr. Sinclair White we both came to the conclusion that the obstruction was due to an impacted gall-stone, and advised an operation. The patient was conveyed to a surgical home. After the preliminary surgical toilette, the abdomen was opened in the middle line above the umbilicus, and a search made for the obstruction. A hard substance was felt in the intestine. That portion of bowel was brought to the surface, surrounded with gauze and opened in the longitudinal axis of the gut. Thereafter the stone was extracted. It weighed 2 drachms 6 grains, and measured in the long circumference  $3\frac{1}{2}$  inches, and in the short circumference 3 inches. The mucous membrane of the intestine was united by catgut, and the serous coat with fine silk. The deep portion of the abdominal wound was brought together by a continuous catgut suture; the superficial portion with silkworm-gut. After the operation the stomach was washed out with saline solution till the returning fluid was quite clear. The patient made an uninterrupted recovery.

**NORTH-EAST LONDON CLINICAL SOCIETY.  
CLINICAL EVENING HELD THURSDAY, NOVEMBER 3RD,  
1904.**

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

Dr. A. J. WHITING showed (1) a case of Acute

Anterior Poliomyelitis in a boy, *æt.* 9. The disease was of two months duration, of sudden onset, and all four limbs were affected. (2) An infant, *æt.* 2, with Spastic Diplegia of Cerebral Origin. The lower limbs were quite rigid and the hands were tightly clenched. The child was also distinctly microcephalic, and was very noisy in the ward. The case excited considerable interest and was discussed by several of the members. (3) A man with "Head-Tetanus," which had appeared after an injury. (4) A woman affected with Glosso-Labio-Pharyngeal Paralysis.

The PRESIDENT remarked that several cases of the latter disease which had come under his notice had met with a sudden fatal termination.

Dr. J. W. HUNT exhibited a man, *æt.* 59, with Cancer of the Neck. The history was that six months ago stiffness of the skin of the neck was observed, and a hide-bound condition of the cervical tissues upon the right side had gradually developed since that date. A small portion removed under chloroform showed microscopical evidences of malignant disease. The question of the possibility of relieving the pain by exposing the patient to the X-rays or to radium was discussed by several of the members.

Dr. NORMAN MEACHEN showed a young man, *æt.* 18, the subject of Tar-Acne. The patient, who was also affected with psoriasis, had applied tar to his back and shoulders somewhat vigorously during the past year.

Dr. R. B. MARJORIBANKS showed a skiagraph of an interesting deformity of the hand in a man, affecting the middle and ring fingers.

Dr. F. J. TRESILIAN (Enfield) showed a little girl with a Thyro-Glossal Duct Cyst, which was of long duration, but was said to have increased in size lately.

Mr. HERBERT W. CARSON remarked that the cyst was probably dermoid in origin, and he advocated excision in the submental region.

Mr. CARSON then exhibited two cases of Fractured Patella in men treated by operation. The fragments of the patella in both cases were not wired, but sutured with catgut in the peri-patellar aponeurosis in a circular fashion. The duration of the operation was considerably shortened by this procedure and the difficulties consequent upon the employment of silver wire were avoided.

Mr. CARSON also showed a man with a Primary Chancere of the Lower Lip.

Dr. T. D. MANNING (Hoddesdon) exhibited a man with an Acute Vesicular Eruption localised to the hands. The lesions consisted of tense vesicles, some of which had become purulent, and were situated upon the thenar and hypothenar eminences and dorsum of the hands. The central portion of the palms was only very slightly affected. The condition was strongly suggestive of cheiro-pompholyx, especially as the patient suffered from sweating of the hands.

Dr. MEACHEN, while admitting the close resemblance of the eruption to pompholyx, considered it to be a vesicular eczema, in view of the fact that the lesions were of small size, and grouped in profusion upon the dorsum of the hands and sides of the fingers, the central portion of the palms being practically spared.

Dr. D. M'CAKIE concurred in this view, the opposite opinion, namely, that the eruption was of the nature of a dysidrosis, being advanced by Dr. TRESILIAN.

The PRESIDENT showed a young woman, the subject of Chronic Pulmonary Tuberculosis, in whom a Pneumothorax had developed upon the left side. The patient was able to go about quite well, and, in fact, walked into the room.

Dr. G. P. CHAPPEL exhibited a specimen of the liver from a case of Acute Yellow Atrophy, which had recently been admitted into the Tottenham Hospital under his care. The patient was a girl, *æt.* 21, who had become infected with syphilis four months ago. Jaundice appeared soon afterwards, and vomiting, mental symptoms, and increasing weakness led to her admission into hospital. The liver dulness was greatly diminished, and death resulted from coma. At the autopsy the liver was very small, weighing only 25 ozs.,

and it presented all the characteristic features of the disease. Leucin and tyrosin crystals were found in the urine.

The PRESIDENT remarked that recent childbirth and an antecedent syphilis were not at all uncommon predisposing causes of this rare affection.

## THE CHILDHOOD SOCIETY.

MEETING HELD OCTOBER 27TH, 1904.

### THE PHYSICAL CONDITION OF THE WORKING-CLASS CHILDREN.

#### THE PROPER FEEDING OF CHILDREN.

SIR JOHN GORST, M.P., opening the meeting of the Childhood Society to discuss a paper read by Dr. Macnamara, M.P., said the question of the proper feeding of children was important to the future greatness of Great Britain as a world power. As the law compelled children to be sent to school it should see they were in a fit condition to receive instruction.

Dr. MACNAMARA, M.P., then read his paper on the subject. After thirty years' practical experience as teacher and member of the London School Board he had come to two conclusions—(1) that 80 per cent. of the children were better off now than ever; this improvement was due to compulsory education, physical training, and the influence of this on home life; (2) That the remaining 20 per cent. were in an almost hopeless condition. Food, clothing, and housing were bad. Especially was the food unsuitable and insufficient, not only in big cities but in agricultural districts. The London School Board had had several meetings on the subject, and at a special meeting in 1898 concluded that it should no longer be left to charitable relief but ought to be a public obligation. Also that where parents neglected their children through drunkenness or idleness, the Board should have power to prosecute them. Dr. Macnamara considered this last clause very important and regretted that it was rejected finally by the Board. He suggested remedies for the evil which was crippling so many, mentally and physically, and explained a scheme already working in Paris that strengthened instead of weakened parental responsibility. This scheme was:—That dining-rooms should be connected with each school, and parents be invited to buy coupon tickets for wholesome and substantial meals served in these rooms. Gratis tickets to be given to those who could not pay for them, after inquiry. All coupons to be printed precisely the same way, the money for gratis coupons to be recovered if possible by the officers of the Board or deducted from the parents' wages. He thought many parents of the well-to-do artisan class would find it convenient and economical to avail themselves of this communal system. A halfpenny rate for feeding children would finally cost the ratepayers less, as the number of healthy wage-earners would be increased. A system of medical inspection would also improve the condition of the school-children. Evening classes of cooking, hygiene, and domestic economy for young women would be of great advantage. All boys between 14 and 20 should be compelled to give two evenings a week to training, under State auspices, which would include gymnastics, formations of companies and drill, and use of rifles. He strongly urged this, although it sounded like conscription; and also drastic changes in the present state.

Dr. CARR, chief officer of the L.C.C., thought the reports of underfeeding were often exaggerated. He did not approve of the coupon system, as it was open to so much abuse; the wisest thing was to take the child away from parents who could not feed it. Hygiene was more important than some subjects now taught in the schools.

SIR JOHN GORST, in moving a vote of thanks to Dr. Macnamara, insisted that children ought to be protected by law from the neglect of parents, though at present, short of employing the criminal law, it was not possible to do so.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 6th, 1904.

## BLOOD-LETTING IN ECLAMPSIA.

THE treatment of eclampsia, says M. Macé, has undergone important modifications in modern times. Among the means employed against it there is one which had by turns the favour and the reprobation of medical men, *viz.*, blood-letting. "For my part," said M. Depaul, "I do not hesitate to declare that the success obtained I owed to blood-letting. I am one of those who are the warmest partisans of this method of treatment. After having employed in very numerous cases the different methods of treatment recommended against eclampsia myself, I do not hesitate to place blood-letting in the first rank." Since then, the partisans of bleeding at the Maternité of Paris are Dr. Porak and myself, and we find in this method considerable advantages.

Blood-letting is beneficial, and frequently the medical attendant will congratulate himself on having employed it, if he has done so largely, sometimes repeating it on the same patient.

The eclamptic patient suffers from poison of all the organs by the retention in the maternal organism of toxic products which determine disorders in the functions of all the cells, provoking convulsive seizures, either from the condition of the blood or from œdema existing in the nerve centres. The œdema of the cellular tissue is frequently manifest in the extremities, but clinical experience has shown that this œdema can, in certain affections, be localised in the bulb, &c., and produce very grave accidents.

Eclampsia, which announces itself by convulsive attacks—a terrifying and visible symptom—furnishes to the medical attendant a certain number of other symptoms which are also important, arterial hypertension, for instance. Hence, congestion of the kidneys, the possibility of the rupture of a small vessel under the influence of high pressure, and, unfortunately, among the arteries which yield the most frequently are those of the nerve centres. Such, in a few words, are sufficient considerations to indicate the necessity of blood-letting.

Peter recommended it against the renal congestion, which he considered the only cause of eclampsia. Playfair reserved it for cases where there were evident signs of cerebral congestion with vascular tension, lividity of the face, bounding pulse and strong pulsations of the carotids.

Professor Bouchard proved by experiments that in eclampsia the drawing of twelve ounces of blood eliminated one drachm of poison, and to arrive at the same result by purging the patient, diarrhoea bordering on cholera should be provoked, which would thus compromise the life of the patient.

At the Maternité we bled all eclamptic patients systematically as soon as they arrive, without regard to symptoms, and we bleed largely. The least amount drawn was twenty-five ounces, sometimes renewed in the same day. By this means we remove a certain quantity of poison, poison whose nature is not yet well defined, but whose constant presence is the cause of the accidents.

The results of blood-letting might be mentioned as follows:—decrease of the toxic elements of the blood, decrease of the vascular pressure, decrease of the symptoms of asphyxia, decrease of œdema.

## HÆMOPHTYSIS IN PHTHISIS.

Chloride of calcium, drs. j ;

Syrup of opium, oz. j ;

Water, oz. v.

A tablespoonful every two hours ; or  
Hydrochlorate of hydrastinin, gr. ij ;  
Water, oz. v.

A dessert-spoonful every half-hour ; or  
Hydrochlorate of hydrastinin, gr. x ;  
Water, oz. iiss.

For subcutaneous injection. A full syringe (1 gr.) once or twice in the twenty-four hours ; or

Hip. powder, gr. j ;

Dover's powder, gr. ij.

For one wafer : One every hour until nausea sets in.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 6th, 1904.

## ALCOHOL AS A FOOD.

HR. ROSEMANN has an article on this subject in Pfüger's *Archiv*, Bd. 100, which, considering the amount of attention that is being at present bestowed on the alcohol question in Germany, is of interest. According to the writer, the views of the unconditional opponents of alcohol with regard to the question of its nutritive value are not in accordance with actuality.

Of the quantity of alcohol introduced into the system, a little over 2 per cent. leaves the body unconsumed. The elasticity given assists the bodily functions, and limits the consumption of other food material introduced. The albumen-sparing action is not noticeable during the first few days of its use, but later on it becomes evident as in the case of carbohydrates and fats. The interesting fact of the absence of albumen-sparing property during the first few days of its use cannot be explained by its washing out remaining terminal products of tissue change. Rosemann sums up the results of all experiments on the subject to the effect that alcohol in regard to its action as a food stands exactly on the line of carbohydrates and fats.

As regards its poisonous action in large doses, he does not believe that moderate doses of alcohol have any poisonous action. For the determination of this question, however, no material is at hand, and it would be difficult to procure it. Bismarck and Goethe would scarcely have done more, or lived longer, if they had been total abstainers.

In any case, the use of alcohol as a food to the healthy individual is not in any way prejudiced by any supposed poisonous by-effects. He would in no way minimise its practical and most valuable action as a food.

## INTESTINAL ANTISEPTIS.

In a discussion on this subject (Merck's *Archiv*), Dr. Soln Cohen made a suggestion that may lead to useful results. Everyone knows the difficulty there is in isolating and capturing any specific bacillus that may be causing mischief in the intestinal canal, and valuable time may easily be lost in making such bacteriological investigations as shall identify the offender. In order to shorten the way out of this difficulty he suggests the use of combined intestinal antiseptics, guaiacol carbonate (duotal), benzo-naphthol and bismuth salicylate. By this combined method he believes that the septic action of many groups of bacteria will be materially limited.

## THE GENESIS OF PULMONARY PHTHISIS.

A discussion on this subject took place at the Naturforscherversammlung, introduced by Hr. Aurfrecht, of Magdeburg. He had never observed that phthisis began by inspiration into the healthy lung. The diseased walls of the blood-vessels caused the caseous tubercle of the human subject. The tubercle bacilli forced themselves into the blood-vessels, possibly through the tonsils, the glands of the neck, and mediastinum.

Petruschky laid the commencement of phthisis in childhood ; scrofulous glands indicated it. Timely and efficient tuberculin treatment gave a prospect of recovery.

Wassermann held tubercle in the veins to be accidental. In a case in his own practice the cervical glands were first diseased and later on pulmonary consumption set in.

Lugenbuhl did not understand what Petruschky meant, and the latter explained that tuberculous women might get over their confinements without

danger, and that prophylactic treatment of young children with tuberculin might enable them to avoid grave tuberculosis in their offspring.

In the Section for Gynaecology, Hr. Schenck described his

#### COMPARATIVE EXAMINATION OF BLOOD.

He could prove that the resorption of tissue elements during involution of the uterus played a part. He was also able to recognise a distinction between the streptococci of the normal lochia and the streptococcus pyogenes. The difference was morphological, and also in staining characteristics and culture. Polano, Würzburg, found, contrary to the general assumption, that in the human subject the antitoxin passed from the mother to the foetus through the placenta, and that this was the case in both active and passive immunisation. Living cells were not bound by simple physical laws, and he instanced the varied composition of the chemical elements of the protoplasm in the different parts of the body.

#### VERONAL POISONING.

Three cases are reported by Dr. P. A. Fenger Just (*Deutsch. med. Zeit.*, Bd. 83, 1904). The first was that of a woman, æt. 25, who for sleeplessness had taken various hypnotics without any special result. She took then, in the evening,  $7\frac{1}{2}$  grains of veronal for a week together, with eight hours' restful sleep. After the ninth dose she had a heat and such itching about the ears, arms, and legs that she could not stay in bed. There was thirst, and then a rash of confluent reddish-violet spots all over the body, which disappeared in ten days.

Case 2 was also one of a neurasthenic single woman, æt. 28. A dose of  $7\frac{1}{2}$  grains of veronal for six nights in succession acted well, but the seventh was followed by symptoms similar to those described in the preceding case.

The third case was that of a woman, æt. 52, who had had an abscess opened in the right hypochondrium, from which a large quantity of stinking pus was evacuated. Being sleepless, she was given  $7\frac{1}{2}$  grains of veronal every evening for five evenings; then for two evenings  $3\frac{1}{2}$  grains were given, and after the second the same itching and rash appeared. In three days it was gone.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 5th, 1904.

#### HEPATIC CIRRHOSIS.

At the Naturforscher meeting, Kretz gave an exhaustive description of the various causes of hepatic cirrhosis which may be concisely stated in the shape of a few axioms:—

1. Interstitial hepatitis does not produce granular cirrhosis of the liver, but parenchymatous changes from repeated attacks and recovery lead to degenerative cirrhosis.

2. The elastic fibres gradually disappear from the fibrous tissue of the organ, leaving the vessels supported by the hard degenerated paenchyma of the organ. The arterial portion of the liver is not the first portion to be attacked but is gradually invaded from the parenchymatous centre.

3. In his third section he laboured the question of hepatic cirrhosis being a morbid entity, or, in other words, having a specific virus. He contended that it was not, as it depended upon cell degeneration for its origin; these degenerated cells localised themselves, forming a neoplasm, which finally invaded the whole organ, subsequently displacing the whole of the healthy tissue.

The etiology of the disease depended on all the causes that produced degenerative changes in the parenchyma, such as poisons, imperfect metabolism, bacterial action, &c. There is also another source of injury to the hepatic cells through the hæmatic circulation or the capillaries of the gall-ducts.

Naunyn thought these different forms of cirrhosis could not be diagnosed with any hope of accuracy, although for classification pathologically he would willingly arrange them as incipient cirrhosis, atrophic or ascetic cirrhosis, biliary or hypertrophic cirrhosis, and Eantic or hypersplenic cirrhosis. These different forms of cirrhosis do not depend upon the different causes of the morbid process, but rather on the complications of cirrhotic cholangitis, which may be considered an intestinal ascending cholangitis, which is not the direct cause of the disease but a factor leading to the morbid process. The differential diagnosis of intestinal and splenic cirrhosis is not clearly established, although the hæmogenic form is conceivable and logical. In the latter case hæmolysis plays an active part in the cirrhotic cholangitis, which may be termed descending cholangiolitis.

The symptoms of this disease are sometimes obscure, owing to the variety of disturbances affecting the function of the liver. Alimentary levuloseuria is a doubtful condition as we do not yet know exactly whether the sugar is directly taken from the blood. The diagnosis of cirrhosis depends chiefly on the anatomical changes. Leichtenstein was the first to announce that cirrhosis of the liver was preceded by enlargement of the spleen, and that cirrhosis of the liver never preceded this condition, but later investigation has proved that the early stage of the disease has the hardened condition of the liver as early as it can be distinguished in the spleen. Banti's cirrhosis has nothing specific to distinguish it, as the large spleen, anæmia and hæmorrhagic diathesis are common to all the forms of the disease, although age may be suspected as an important factor in the development of the hypersplenic form, which has strangely been called pseudo-Banti's disease, apparently depending upon a toxæmic albuminoid which is cured by extirpation of the spleen. Closer inspection of the anatomy shows that this form of cirrhosis is not the genuine hepatic hardening, but only an increased growth of the hepatic cells in the acini. This condition, he affirmed, often took place in cases of lithiasis or after hepatic colic. He was inclined to believe in the cause being an infectious inflammation of the gall-duct as cholangitis cirrhotica was a frequent and important complication in the symptoms commencing with fever, vomiting, and icterus. He could not accept cholangitis ascendens as a cause of cirrhosis as the transformation of cholelithiasis into cirrhosis has never been observed. In his opinion the etiology of cirrhosis was alcohol, which may sometimes be associated with lues, typhoid, and the puerperium. The changes observed in the bowel and spleen by Bleichröder are not specific symptoms, but are common to all hepatic changes. Neither can the blood be used for diagnostic purposes as no specific blood change can be defined, yet we are unable to deny the possibility of a hæmatogenic origin as the toxin may pass from the bowel into the hæmatic circulation and produce irreparable damage to the follicles of the corpuscle, which may be one explanation for Kretz regularly finding "hæmachromatose" in the liver. It is common knowledge, however, that alcohol injures the erythrocytes of the blood and retains them in the liver till they become destroyed, leaving the *débris* in the organ as a centre of destruction.

Aufrecht wished it to be clearly understood that interstitial inflammation did not exist in cirrhosis, but only an apparent increase of the fibrous tissue owing to the solution of the acini, which gave the section of a cirrhotic liver a smooth appearance. He gave it as his opinion that the initial stage of cirrhosis could not be diagnosed as many simple enlargements disappear quite easily without any evil consequences, although others may end in acute atrophy and become decidedly cirrhotic.

Chiari directed the attention of the members to the enormous growth of the parenchyma in cirrhotic conditions. It was never constant in quantity, but varied considerably as clinical differences went to prove. In addition to this there was often a secondary inter-

stitial process. He related a number of cases that ended fatally in necrosis.

Bebes showed a photograph of a primary parenchymatous centre, which partially passed through secondary degeneration.

Bleichröder related the results of his histological examination of the stomach, bowel, spleen, and marrow in hepatic cirrhosis, which, he said, resembled pernicious anæmia in every detail.

Frey-mouth said that he once diagnosed a case of incipient cirrhosis after having performed laparotomy for a neoplasm in the liver!

Steinberg disagreed with Bleichröder's conclusions as the breaking down of the lymphocytes in the blood-vessels or the changes in the fibrous cells could not be shown.

Hanse-mann said that he had seen two cases of cirrhosis that had arisen from inflammation of the gall-ducts. He was not a believer in the alcoholic etiology of cirrhosis because many men and women drank to excess and no cirrhosis ever occurred.

## Bungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, November 5th, 1904.

At the October meeting of the Interhospital Medical Association, held here, Dr. T. Gáspár introduced the subject of

### EARLY DIAGNOSIS IN MENTAL DISEASES.

He defined insanity, according to Burr, as a "prolonged departure from the individual's normal standard of thinking, feeling, and acting." A comprehensive definition would include mental defect from whatever cause, and mental perturbation of whatever degree. Any or all of the elemental processes of sensation, perception, ideation, reasoning, judgment, memory, may be impaired in insanity. In his paper, the nature and degree of impairment of these elemental processes and of emotion and volition in different forms of insanity, were touched upon. Subjects discussed at greater length were the distinction between confirmed inebriety and true insanity of alcoholic origin; the differential diagnosis of alcoholic pseudoparesis and parietic dementia; certain phases of hysteria, and the diagnostic difficulties pertaining to paranoia and recurrent mania. Neurasthenia was a euphemism often employed to obviate the necessity of plain speaking, or might be used erroneously to explain symptoms in the early stages of an organic malady. The self-deception on the part of the physician or his inaccuracy in diagnosis led to improper methods of management, and the prescription of travel often made for such patients was deplored and incidentally hospital care for neurasthenic cases was advised.

Dr. Makkay delivered an address on the  
PREVENTION OF HEART DISEASES.

He discussed in what manner the principles of prevention could be applied to various heart affections. He regarded the removal of all chronically diseased tonsils (this was first recommended by Dr. R. Babcock, of Chicago) as of the utmost importance in all persons who had once had an attack of inflammatory rheumatism, whether the heart had been damaged or not. If infection could be prevented, cardiac inflammation could likewise be obviated. This statement applied to other affections than rheumatism. He then mentioned syphilis and gonorrhœa, saying that these diseases sometimes attacked the cardiac structures. Pneumonia, chorea, scarlatina, are sometimes accompanied or followed by acute or chronic endocardial mischief, while influenza or diphtheria may attack the myocardium in an inflammatory way, so as to seriously impair its integrity. Until we could prevent such infections, we could not guard against the cardiac structures being attacked. The author discussed chronic myocardial diseases, the toxic influence of syphilis, alcohol, and chronic lead poisoning, fatty heart, and particularly cardiac overstrain, as it is

observed in the young, and sometimes in the middle-aged, and apparently healthy, as the result of excessive physical exertion, and mentioned typical examples of this kind.

### HEREDITARY SYPHILIS.

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

## The Operating Theatres.

### ST. THOMAS'S HOSPITAL.

OPERATION FOR PERFORATED GASTRIC ULCER.—Mr. BATTLE operated on a man, *æt.* 52, who had been under the care of his colleague, Dr. Hector Mackenzie. The patient had been complaining of stomach symptoms for two or three years, and had been admitted under the care of Dr. Mackenzie for an increase of these symptoms, which led to the diagnosis of simple ulcer of the stomach situated near the pyloric extremity associated with dilatation of that organ. The man complained of a good deal of epigastric pain and of vomiting, the quantity of material brought up being rather large, and three days before operation he had been put on rectal feeding, because his pain had been so severe. At ten o'clock on the previous night he had complained of increase in the pain, and had become much worse. When seen shortly before operation he was lying on his back, with a pale face and distressed expression, breathing rapidly, but not employing his diaphragm or abdominal muscles more than was absolutely necessary. He had much abdominal pain, chiefly in the upper part of the abdomen. On examination, the latter was found to be slightly distended, rigid and without movement on respiration. It was tender on pressure, and there was evidence of considerable fluid throughout, both in the flanks and above the pubes. The liver dulness was not lost, nor was there evidence of free gas in the peritoneum. Operation was performed about eighteen hours after the time of the probable perforation. A median incision was first made in the epigastric region; on opening the peritoneum a large quantity of sour-smelling greenish fluid escaped. The omentum and lower margin of the stomach were attached to the under surface of the liver by means of recent exudation, but these attachments separated directly the finger encountered them as it was passed towards the pyloric end of the stomach in search of the perforation or of evidence of chronic thickening. At this point there was an escape of free



gas. The finger readily located the ulcer, the opening being so large that the end of the finger could be easily passed through it into the stomach; its margin was very sharply cut, and the area of induration extended for about an inch and a half around it. The stomach was dilated. The pyloric end was drawn forward and held in position by Mr. Birks, the house surgeon, whilst sutures were inserted. On account of the size of the ulcer two sutures were passed to approximate the edges of the perforation; then a row after Lembert's method to cover it over completely, and finally an additional suture to take off some of the tension, which seemed to try some of the second row of stitches. The silk employed was No. 2, because it was found that smaller sizes than this cut their way out at once. Another opening was made in the middle line above the pubes and the whole peritoneal cavity thoroughly cleansed with warm saline solution until the liquid no longer had any colour or sour smell. The fluid which had escaped in the first instance from the perforation must have amounted to several pints, as it filled the pelvis and the flanks, and had collected to a large amount in the splenic region and about the right lobe of the liver. The upper wound was closed in three layers by means of interrupted sutures, whilst a drainage-tube was left in the pelvis, coming out through the lower wound. Towards the end of the operation the patient's pulse failed somewhat and he began to show signs of collapse; an infusion into the left arm of two pints of normal saline improved his condition rapidly, and he soon recovered. Mr. Battle pointed out that the ulcer had been found in the position where the physician had diagnosed its presence, and the other conditions were as expected; the only unusual thing about the case, he thought, was the large size of the opening into the stomach and its extremely sharp-cut cicatricial edges. The diagnosis even in the absence of proof of free gas, he said, was quite easy, and the patient was already in an exceptionally good condition as the result of nearly three days' treatment by rectal feeding. The ulcer, together with the inflammatory swelling round it, did not appear to actually obstruct the pylorus, but was close to it, and there was no doubt that obstruction had been present, as was shown by the dilated condition of the stomach, for which he thought it might possibly be necessary to do a gastro-enterostomy at a later date.

The operation relieved the man at once, his pain being completely gone when he recovered consciousness, and since that time he has progressed most favourably.

#### GREAT NORTHERN HOSPITAL.

##### SUPRAPUBIC CYSTOTOMY.— HOUR-GLASS BLADDER.

—Mr. PEYTON BEALE operated on a man, æt. 54, whose history was as follows: He was a shunter in the employ of the Great Northern Railway, and had been able to work until about six months ago, when he complained of pain in the left loin extending to the abdomen and to the left leg; he also passed some blood with his urine, and was treated by a doctor for stone in the left kidney. He was sent to the hospital by Dr. G. R. Williams. On examination under an anæsthetic a sound was passed into the bladder as a routine process, and after some slight obstruction had been encountered about the membranous urethra a stone was easily felt lying at the base of the bladder, not encysted; one or more smaller stones were also to be felt. It was

noticed that the capacity of the bladder was small, and it was known that the man had increased frequency of micturition and passed only three or four ounces of urine at a time; but these being not unusual symptoms in connection with stone or stones in the bladder, nothing much was thought of them. On abdominal palpation there was nothing to indicate any derangement of the left kidney. As there had clearly been some old urethral trouble whereby the urethra would only now admit a No. 6 instrument, it was thought advisable to perform suprapubic cystotomy in preference to a perineal operation. A few days later, therefore, suprapubic cystotomy was performed, a Lister's sound having been introduced into the bladder and the stone again detected. The bladder was easily reached and at once recognised; but in a higher position than was expected from its apparent size at the first sounding. The bladder was opened and was found to contain no urine, nor could the sound and stone be detected in it. On further examination the instrument and stone could just be reached by the tip of the forefinger very deep down in the pelvis. It was then evident that this latter was the functional bladder, and that the large cavity above was completely shut off from it. It should be remembered, Mr. Beale now pointed out, that previous attempts at distending the bladder by fluid injections had been quite unsuccessful. As the portion of bladder containing the sound and stone could not be reached through the suprapubic wound sufficiently to enable the stone to be satisfactorily dealt with, the upper part of the bladder was stitched up and the abdominal wound closed in the usual way. Mr. Beale said that the case was interesting for two reasons: First, because all the man's symptoms pointed to a derangement of the left kidney. In all urinary cases he considered it advisable always to examine the patient under an anæsthetic and explore the bladder at the same time, because it was a very noticeable fact that a stone might exist in the bladder for a long period without giving rise to classical symptoms. Secondly, the hour-glass contraction was of interest; such cases, he thought, were very difficult to deal with, for when the stone was lying in a small bladder lithotripsy was not desirable even if the urethra was normal. By suprapubic cystotomy it was often, as in this case, he said, not possible to remove the stone satisfactorily; and in his experience if perineal section or lithotomy were performed a permanent fistula was a very common complication, due apparently to the fact that the small bladder continually expelled the urine as it entered it and allowed little if any of the fluid to accumulate in it.

#### The Royal University of Ireland.

At a meeting of the Senate, on Thursday, October 27th, the results of the recent examinations were received and Honours exhibitions and prizes awarded. It was resolved that, subject to certain restrictions, the books in the University library and the University grounds should be made available for graduates of the University during portions of the year.

The following have received the M.D. Degree:—George Adams Hicks, M.B., B.Ch., B.A.O., Daniel Lee, M.B., M.Ch., M.A.O., John Elder MacIlwaine, M.B., B.Ch., B.A.O., Michael Joseph Mahony, M.B., B.Ch., B.A.O., John Hope Reford, B.A., M.B., B.Ch., B.A.O., John Stewart Ferguson Weir, M.B., B.Ch., B.A.O.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 9, 1904.

**THE SMALL HOSPITALS AND THE FUNDS.**

THE smaller hospitals of the Metropolis, and to a less extent of the provinces, have during recent years been faced with increased difficulties in maintaining their existence. The struggle has been no doubt partly due to the scarcity of money which has resulted from depressed trade and depleted national wealth. Another cause has been the diversion of huge sums of money in answer to appeals issued to the public by the great general hospitals one after the other, in some cases to be repeated after a few years' interval. The chief cause of the decline of the small hospitals, however, has in all probability been the policy of the Sunday and the King Edward's Hospital Funds, which, whether intentionally or otherwise, has resulted in the withholding of grants and injury to the reputation of a host of small but deserving medical charities. The relation of the lesser hospitals to the Funds is peculiar. When the Funds were started as collecting and distributing agencies, the small hospitals sacrificed the income derived from special collections in places of worship. They next lost the support of many subscribers who withdrew or refused subscriptions on the ground that they contributed to the Funds. Finally, the Hospital Sunday and the King Edward's Hospital Fund have in many cases refused grants to small hospitals. It will be seen, therefore, that in this case the poor hospital has lost much and gained nothing. Furthermore, the refusal by a Fund of a grant to any particular hospital is looked upon by the general public as a slur upon the character of that institution. So that loss of character as well as of income is the inevitable

fate of the small hospitals under the Fund methods of distribution of alms. In other words, the days of the small hospital are numbered under the control of the Funds. We venture to assert that this result is due to the deliberate policy of those who administer these, and was never contemplated by the public whose money had previously been given freely to the medical charities, great and small. It is necessary here to state clearly that the Hospital Saturday Fund supports loyally and consistently the smaller hospitals. The Saturday Fund is controlled mainly by representatives from the hospitals and from the classes who are benefited by the hospitals, and they are accordingly from that point of view peculiarly fitted to judge what charities do and do not deserve support. We find the Saturday Fund extending the hand of practical sympathy and help to the smaller hospitals, whereas the sister Funds have to a great extent taken away both income and character. Which is right, the Hospital Saturday on the one hand, or the Hospital Sunday and the King Edward's Funds on the other? The administration of all these Funds is, happily, in the hands of honourable men; but while that of the Saturday Fund, as already pointed out, is democratic, that of the other two may be termed aristocratic and even autocratic. The latter term may sound harsh, but it is not easy to find any adequate alternative to express the policy of a Fund that deprives small hospitals both of income and of character without clearly stating the principles, general and particular, upon which their action is based. The principles of the Hospital Sunday and the King Edward's Funds cannot be gauged from ordinary observation and reasoning. If there be one principle paramount in those Funds it is the advocacy of payments by hospital patients. If the principle be right, it follows that the hospital which receives the greater part of its costs of treatment from patients is the better hospital. Yet the Funds deny grants to institutions where patients' payments exceed a certain proportion of income. The economy with which a hospital is managed and the smallness or absence of debt appear not to influence grants except perhaps in inverse proportion. Why should not the small hospitals and the poorer classes be adequately represented on the Hospital Sunday and the King Edward's Funds as they are on the Hospital Saturday Fund? Far be it from us to say one word against the good faith and the immaculate honour of both those Funds. They are public bodies, however, and are therefore open to criticism. We are no less willing to praise their virtues than we are ready to criticise their defects. The faults, we believe, may readily be remedied. Our great and wise King, who created one of these bodies, may with a stroke of the pen revise the constitution of his Hospital Fund, so as to make it more generally representative of all classes, and at the same time remove what, in our opinion, constitutes a grave injustice to the small

hospitals, which are in many instances carefully administered, ably officered and old-established institutions, invaluable alike to the public and to the medical profession.

#### THE VITAL STATISTICS OF IRELAND.

THE fortieth report of the Registrar-General for Ireland, which has recently been issued, does not show any new factor influencing the population, which continues to decrease in practically the same proportion as during the past ten years. The total number of births last year, presenting precisely the same rate per thousand of the population as the average for the past ten years, was 101,831, exceeding the number of deaths by 24,473. This shows a fair natural increase in the population, but, unfortunately, it is more than counterbalanced by the loss through emigration, amounting to 39,789. It will be seen that the decreasing population is not due to any vital causes, but to economic and, as some hold, to sentimental ones. There is little doubt that the economic position of Ireland is, during the last few years, improving, so that it is disappointing that the emigration figures are as high as ever. Trade in both large and small towns is livelier than in the eighties, agriculture is conducted by more intelligent methods, and the settlement of the land question gives the occupier an interest in his toil he never had before. Nevertheless, the steady drain of the best blood of Ireland continues from Derry in the North as from Queenstown in the South. It is truly an appalling fact that every year the loss by emigration is more than half that by death. Under the circumstances it is matter for surprise that the death-rate is so moderate as we find it—last year  $17\frac{1}{2}$  per thousand—since it is the young and strong who go, and the old and infirm who stay. Melancholy reading as is the Report as a whole, there are yet some points of relief. The vitality of the people is by no means low, as evidenced by the high birth-rate taken in proportion to the marriage-rate, and it is probably some evidence of prosperity that the latter shows during the past few years a steady increase. The number of persons married as minors is very small—of men, 1.57 per cent., of women, 6.50—and is in marked contrast to the numbers noted in industrial populations. The rate of illegitimate births shows a similar contrast. The percentage of children born outside wedlock is only 2.6, varying from 0.5 in the agricultural population of Connaught to 3.3 in partially industrial Ulster. A point of interest in the list of certified causes of death, showing, too, the remarkable vitality of the Irish people, is the number of deaths returned as due to "old age," many of them at ages exceeding ninety-five years, and 176 at ages over one hundred. "Old age," indeed, is made accountable for the highest number of deaths, with the exception of tuberculosis. While in England and Scotland the mortality due to tuberculosis has steadily dimin-

ished during the past thirty years, in Ireland it has remained stationary, with, in late years, a slight tendency to rise. The problem of the check of consumption is one of the utmost public importance. Public men are busy in schemes to lessen Irish emigration, and we wish them every success, but we think that enough attention is not given to the more easily preventable loss of population by tuberculous disease. A few, but only a few, boards of guardians are awake to its real importance, though the medical profession does its best to call attention to the matter. The death-rate from cancer continues to increase in Ireland, having reached its highest point last year. We think, however, that the Registrar-General is right when he points out that the increase is more apparent than real, since diagnosis and classification are becoming more accurate. The zymotic death-rate is, as one would expect, low, influenza being the most important zymotic disease tabulated.

#### MILK-BORNE DISEASE.

A CASE of the greatest interest to milk-consumers—that is to say, to the whole British public—came last week before the courts of justice. The facts disclosed were that a lady was taken ill in July, 1903, with typhoid fever, and eventually died. In the district in which she lived there were at or about the same time twenty-one cases of the disease, and twelve of these patients drew their milk supply from one dairy. The medical officer of health made inquiries and he came to the conclusion that the source of the outbreak—at any rate, as regarded the latter twelve cases—was due to the milk they had been drinking. The lady's husband brought an action against the dairy company for the loss he had sustained by reason of the death of his wife and for the out-of-pocket expenses he had incurred through her illness. In evidence it was stated that a case of typhoid fever had occurred in a cottage connected with one of the farms whence the company drew their milk, and it was contended by the plaintiffs and denied by the defendants that there was sufficient evidence to connect this case with the outbreak among the consumers. The plaintiff's counsel relied not only on the general principle that a purveyor is bound to supply food that is not injurious to health, but also on the special statement in the company's advertisements that they were in a position to guarantee their milk to be free from disease germs. Mr. Lawson Walton, for the defence, submitted that the evidence was not sufficient to support the plaintiff's contention, but the judge (Mr. Justice Grantham) held that the case was one of fact and must be decided by the jury. Witnesses were called on both sides to prove whether or no the case of typhoid at the farm had any etiological relation to the cases amongst the consumers, and eventually the jury decided for the plaintiff, only awarding him, however, £106, the amount at which they assessed his out-of-pocket expenses. Judgment

was therefore given for that amount with costs. In some ways it is unfortunate that the particular company against whom this verdict was given should have been the first to suffer in an action of the kind, for they are known to take elaborate precaution to guard their milk from contamination, and it appears to have been through a breach of their stringent rules that the milk from this farm ever got into the general supply. Moreover, when suspicion was aroused and the circumstances were brought to light, the milk from the particular farm was at once withdrawn. There will always be a possibility of flaws in the best organisations, and in this case the company had to suffer from a fault that could only be indirectly attributed to them—that is, assuming that the case of typhoid at the farm was really the cause of the outbreak. As to this, although the jury held that it was the cause, there was a good deal of conflicting evidence, and indeed, in the present state of medical knowledge it is seldom possible to establish an irrefutable chain of evidence in circumstances of the kind. However hardly in this instance the jury's verdict may press on the company, we are inclined to see in the principle of this action a method for solving the problem of the present highly unsatisfactory state of the milk trade generally. It has now been held by a judge, and confirmed by a jury, that the sale of milk carries with it an implied warranty as to its wholesomeness, and that in the event of damage resulting to the consumer an action for damages will lie against the vendor. In the event of disease arising from any contamination of milk, any and every person injured thereby will have a *prima facie* case against the purveyor; and the recognition of this liability by the trade cannot, one would think, but tend to make them take their responsibilities far more seriously. As we have more than once pointed out, the difficulty in setting this important trade into satisfactory order lies in the multiplicity of hands through which the milk passes before it finds its way into the domestic jug, and, where responsibility is divided, it is notoriously hard to fix blame. Now that it has been held that the vendor is the responsible party, he will probably take every care to see that he is not let in for expense and damage by those from whom he draws supplies, and thus the whole array of agents who have to do with the supplies of milk—farmers, servants, railway companies, and collectors—will be made aware of their duties and responsibilities to the purveyor and, through him, to the public. Our remarks do not apply with any particular force to any particular dairy company, but to the whole of those persons handling milk who intervene between the cow and the consumer. It is astonishing to compare the energy with which municipal authorities pounce on dairymen who water their milk with the complaisance of those authorities towards vendors who sell milk that is stale, dirty, and perhaps infected with disease. But what legislation and administration have failed to do, what a sanitary department and a standing army

of inspectors have been powerless to touch, now appears likely to be accomplished in the near future if we are to take this verdict as representing the feeling of the public. Milk, which is only preserved from going sour by the addition of boric acid or formalin, and which contains sufficient bacterial products to give diarrhoea to many a score of babies, may now get the vendor into trouble through the most effective channel—namely the pocket. In acclaiming the verdict as a miniature Magna Charta to the milk-drinking public, we are only sorry that the blow fell in the particular direction where it did.

### Notes on Current Topics.

#### Direct Bronchoscopy.

A GREAT deal of the progress in medicine depends on the progress made by the other arts and sciences, and medical diagnosis and surgical treatment has been immensely facilitated by the inventive genius of a few men who have been able to place instruments of precision in the hands of medical men. The laryngoscope and ophthalmoscope are now everyday implements with most practitioners, and several other "scopes" are daily coming to be regarded as an essential part of the consulting-room furniture. Few, however, are yet practised with the bronchoscope, and still fewer have had the opportunity of operating with its aid. Indeed, a great deal of scepticism has been expressed as to the practical utility of the invention. Two German surgeons, Nehr Korn and Killiau, have lately been describing their manipulations with its aid, and in their hands it appears to have been highly useful. Killiau reports his sixteenth case of removal of a foreign body from the bronchi by the assistance of the bronchoscope, and Nehr Korn describes three similar cases that were under his care. The former was consulted by a man aged fifty-six, who had inhaled a piece of chicken bone whilst drinking a plateful of soup two months previously. Convulsive choking followed the passage of the bone into the air-passages, and though this gradually passed off the patient continued to have noisy dyspnoea. The foreign body remained and could not be removed by the surgeons he consulted. Physical signs in the chest pointed to the left bronchus being partly occluded, and the mucous membrane of that tube was seen by the bronchoscope to be reddened. Killiau operated under an anaesthetic, passing the instrument well down into the bronchus, and by its aid he was able to seize the bone with long forceps. When withdrawn the bone was covered with foetid pus, but the patient made a good recovery. Nehr Korn's three patients were all children in whom beans had become lodged in the bronchus, and though he managed by the aid of the bronchoscope to remove these foreign bodies in two cases, in a third he had to perform tracheotomy and pass the instrument through the wound. All recovered satisfactorily. To use the bronchoscope skilfully requires some little practice, but

it should certainly prove a great help in those difficult and dangerous cases of obstruction of the bronchi by foreign substances for which so far surgery has been able to do but little.

#### Surgical Treatment in Gout.

THE medical treatment of podagra is not altogether satisfactory; neither is the surgical treatment. The swollen big-toe joint with its traditional associations of port wine and bad temper, has always been regarded as one of the special preserves of the physician; but nothing is sacred nowadays from the operating surgeon, and one cannot be astonished that he has now turned his attention to the gouty joint. The first occasion was accidental, or rather the result of mistaken diagnosis. Riedal (*a*) was called to see a middle-aged gentleman who, the night following a hard day's shooting, was awakened by severe pain in the right great toe-joint. The joint was much swollen and intensely painful; the skin over it hot and shiny; the body temperature 102° F. Finding that the patient had a condition of hallux valgus, Riedal thought that his trouble was caused by suppuration in a bursa over the metatarsophalangeal articulation which communicated with the interior of the joint. He therefore operated. No bursa was found, and instead of pus the joint was filled with urates and serous fluid under pressure. He decided to continue the operation, and after removing the deposit he took away the capsule of the joint and drained the wound. The patient was entirely free from pain and fever after he came round from the anæsthetic, and never had any further trouble in the toe although he lived for fifteen years afterwards. It was not till twelve years later that Riedal could persuade another patient to allow him to operate for gout, but one old lady was at last found to consent, and he again opened and drained the great toe-joint, after removing the capsule. In her, too, a complete and gratifying recovery followed. No relapse took place for the eight remaining years of her life. One is hardly surprised, therefore, that the surgeon should think that in certain cases of monarticular gout, operative treatment may be as justifiable as it was successful in the two cases recorded. In this country, however, accustomed as people are to the idea of being subjected to the surgeon's knife, we fancy they are not yet prepared to submit their gouty joints to his tender mercies.

#### The Cape as a Health Resort.

FOR many years South Africa has enjoyed, in common with Australia, New Zealand, and Colorado, a high reputation as a health resort for patients suffering from pulmonary phthisis. Recent events, moreover, which have made South Africa appear for the time the land of promise, have directed the attention of many invalids to that country. Under the circumstances, it is important that physicians at home should be in a position to offer advice to their patients who may intend to emigrate, not merely on the subject of the

choice of destination, but as to the necessary conditions of life and probable chance of employment. The most important point to be decided is whether a patient should be advised at all to go abroad. There is no doubt that in many cases a patient, in an advanced stage of phthisis, with cough, expectoration, and pyrexia, will not lengthen his life one day by a change of climate. On the other hand, he merely suffers the misery of his last illness among strangers in a foreign land, away from all the comforts of home and friendship. Still, hope being what it is, one rarely likes to leave untried what may after all be a chance of recovery, and one can recall many cases of recovery even among the apparently hopeless. In going to South Africa, a patient, even in early stages of consumption, must be supplied with sufficient means to keep him for at least a year or two. Otherwise he will probably find his choice of employment limited, and he may be forced into work which will prove disastrous to his health. Great attention must be paid to the choice of residence, the altitude being the most important factor. In the low altitudes in Cape Colony, up to eight hundred feet, there is plentiful vegetation and much moisture, while in the high altitudes of the Great Karroo, two to five thousand feet, conditions are quite opposite. It may, however, be wiser for the physician at home to leave the decision of a suitable locality to a *confrère* at Cape Town, and indeed, a patient should always be warned to lose no time in placing himself under a competent physician on his arrival in a new country.

#### Chloroform Anæsthesia.

IT can hardly be said that the discussion on chloroform anæsthesia which took place at the annual meeting of the British Medical Association has advanced our knowledge of the subject to any appreciable extent. Indeed, there was but little attempt to treat the subject as a whole and most of the discussion centred round Mr. Vernon Harcourt's inhaler. It will be remembered that when this apparatus was first introduced, it was received with such a chorus of praise that one might have been forgiven for imagining that the last word had been said as regarded the method of chloroform administration. It was claimed, not so much by the distinguished inventor as by others, that with this apparatus over-dosage was impossible, and chloroform mortality was to be a thing of the past. Further, the inhaler was so simple in its use that even the most ignorant practitioner could employ it with safety to the patient and comfort to himself. That these exaggerated claims have not been borne out is made abundantly evident by the criticisms to which it has been subjected by competent anæsthetists like Mr. Crouch, of St. Thomas's, and Dr. Levy, of Guy's. It is their experience that not only is it possible for over-dosage to occur, but that unless the chloroform bottle is rigidly secured against shaking there is no guarantee that the percentage of chloroform vapour in the inspired air

(a) *Deut. med. Wochensh.*, August 25th, 1904.

is kept within safe limits. In addition there is the very strong practical objection that the period of induction is extremely long, the average apparently being at least fifteen minutes. As Mr. Crouch remarked, "even the most good-natured surgeon declined to wait the necessary time." On the other hand, Dr. Dudley Buxton has used the apparatus with success in several hundred cases, though, as far as we know, no details of them have yet been made known, and it was more than hinted in the Oxford discussion that there were others in which he had not been so fortunate. Speaking as generally as we can from the evidence at present before us, Mr. Harcourt's inhaler seems a useful invention when in skilled hands, but, like all other chloroform inhalers, requires great care in using, and by no means relieves the anæsthetist of his responsibility in the choice of chloroform as an anæsthetic. We do not, indeed, understand why there has been such a prother as to the best method of administering chloroform. In these countries there is but little necessity for its use at all, seeing that in the great majority of cases it offers no particular advantages over ether, ethyl chloride or gas. When a useful apparatus for administration becomes an inducement to use chloroform for such operations as extractions of teeth, as has actually occurred with the Harcourt inhaler, its introduction may prove an evil rather than a blessing.

#### The Significance of the Diazo Reaction.

THE value of a clinical test becomes obviously impaired when once it is found that there are important and frequent exceptions to its positive reaction. The test discovered by Ehrlich in 1882, known as the "diazo reaction," consists in adding a mixture of sulphanilic and hydrochloric acids containing sodium nitrite to a typhoid urine, when, on alkalisising with ammonia, a cherry-red or garnet ring is produced. This appearance was at first supposed to be distinctive of typhoid fever, but subsequent investigations showed the contrary. Other diseases, such as tuberculosis, scarlet fever and measles, were found to give positive results with Ehrlich's test, so that the hope, which was first entertained, of being able to diagnose enteric fever in the early stages by examination of the urine was not fulfilled. Many observers have since pursued exhaustive investigations upon the subject with results that are not altogether unfruitful. In 1902, the Health Department of New York City undertook the examination of typhoid urines by the diazo reaction, and it was found that this test was more constant even than the Widal reaction. Dr. W. Taylor Cummins, (a) of Pennsylvania, has himself gone over the ground again, having examined 436 urines with regard to their behaviour to the diazo reaction. In typhoid fever, 58.6 of the cases gave positive results, a somewhat smaller proportion than that obtained by most other observers. Dr. Cummins concludes that a relapse

may be differentiated from a complication in the latter disease. It is also stated to be of prognostic import in tuberculosis, as the reaction does not appear until late in the course of the malady, and then persists until death. Typhoid urines gave a positive result with greatly diluted reagents, whereas tuberculous urines did not so respond.

#### An Ophthalmic Surgeon on Legal Evidence.

MR. MALCOLM McHARDY has on several occasions secured the sympathy of the medical profession on the way in which his name has been brought before the notice of the public. The first occasion was when the well-known professor of ophthalmology fell overboard from a yacht, and was rescued after a perilous immersion. This adventure was, we believe, recounted to the newspaper reporters by a friend unversed in the usages of the medical world. His most recent appearance in public is due to his own deeply rooted dislike to attendance in Court to give evidence on behalf of a litigant formerly under his care as a hospital patient. An appearance of that kind undoubtedly involves a good deal of inconvenience and loss to a busy consultant. Fortunately, it is rarely required, and in any case must be accepted as one of the drawbacks necessarily attached to the holding of a public post. As the Courts can compel the attendance of medical men attached to hospitals, we fail to recognise the pertinence of the indignant letter of protest which Mr. McHardy has written to the Editor of the *Times*. Such a remonstrance, moreover, would have been hardly less effective, and certainly would have been more in consonance with the traditions of the medical profession, had it been signed with a *nom de plume* instead of Mr. McHardy's name and an appended list of professional proofs.

#### The Chair of Surgery in Dublin.

AFTER forty years of service on the teaching staff of the School of Physic in Ireland, it is announced that Mr. Edward Bennett has begged to be relieved of part of the duties of the Chair of Surgery. From 1864 to 1873 he held the post of University Anatomist, and it is not too much to say that during most of that time he had practical control of the Department of Anatomy. To him, more than to any living man, is due the setting up of a high standard of teaching of that subject in Dublin, a standard maintained by his colleagues and successors, Macalister, Little, Brooks, and Cunningham. In 1873, he was appointed Professor of Surgery, and he still holds that post. The Board of Trinity College has, however, granted his request to be allowed to direct his teaching duties in theoretical and operative surgery, and to devote his time to the care of the surgical museum, of which he is curator. This museum contains a wealth of material, for the greater part collected and arranged by Mr. Bennett himself, and it is a matter of great importance that he will

(a) *Univ. Penn. Med. Bull.*, September, 1904.



now have leisure to complete the descriptive catalogue on which he has been long engaged. The completion of this work may be looked forward to as the consummation of his forty years' scientific work in Dublin. And it is with pleasure we learn that the Board of Trinity College has arranged for its publication in the University Press Series. Mr. Bennett intends still to continue his duties as Clinical Teacher and Surgeon at Sir Patrick Dun's Hospital. His old pupils all over the world, in whose respect and affection he holds the highest place, will join in wishing him many years of health and activity in the work he loves.

#### "Ether Day."

It is well that the world should keep green the memory of its benefactors, and the more so from the fact that the virtues of illustrious men are often ill-recognised and ill-rewarded during their lifetime. Perhaps one of the greatest of all human discoveries was the discovery of anæsthetics, to be ranked alone with that of antiseptic or aseptic surgery. On Monday, October 17th last, the celebration of the fifty-eighth anniversary of the first administration of ether as a surgical anæsthetic was held at the Massachusetts General Hospital, Boston. The amphitheatre, where the meeting took place, was arranged as nearly as possible to resemble its appearance on the historic occasion of October 16th, 1846. An address was delivered to a densely packed audience by Dr. J. Collins Warren, Mosely Professor of Surgery at Harvard University, the grandson of Dr. John C. Warren, who performed the first operation under ether. He detailed the facts of the discovery, which is still incorrectly described in many quarters. Mr. Jackson, scientific chemist at Boston, first suggested the use of ether as an anæsthetic to a dentist of the same city, Mr. Morton. The latter administered ether for the first time to a patient upon whom Dr. Warren operated in the Massachusetts Hospital. It would be a good idea to place a statue of Sir Humphry Davy alongside that of Dr. Warren and Sir James Simpson in a prominent place in London, as three of the greatest heroes of humanity and benefactors of mankind the world has ever known.

#### Death in "A Pleasant Confection."

WHATEVER views may be held by the medical profession as to their practical exclusion from the court of the London coroner, Mr. Troutbeck, it is clear that the newspaper reporter eagerly gleans the crumbs of wisdom that fall from that gentleman's table. It may be presumed, perhaps, that the natural sagacity attached to that particular species of hybrid legal inquiry is raised to an unimpeachable standard of authority because the medical evidence comes through the mouth of Dr. Freyberger, the Pathologist, or whatever his official title may be, of the London County Council. At an inquest last week the learned doctor stated that he had examined a chocolate cake similar to that administered to a deceased child of six and that it tasted like santonin, which was

often legitimately used as a medicine under certain circumstances, but should never be given except under medical directions. With the latter part of the statement every medical man will cordially agree. It is nothing short of a public scandal that dangerous drugs such as narcotics, irritants and corrosives should be sold wholesale to the public, often under the specious guise of "a pleasant preparation," as in the case under notice, or protected by a patent stamp. There is another side to Dr. Freyberger's evidence. Santonin has an extremely faint, bitter taste. If that were perceptible to Dr. Freyberger beneath the disguise of a chocolate cake, then, indeed, we begin to understand his claims to be considered a great pathologist. As a toxicologist the newspaper report does not mention that he applied the recognised tests for santonin, but Mr. Troutbeck, after all, has not had the benefit of a scientific education, and so would not be likely to cavil at the extremely difficult appeal to the sense of taste.

#### The Belt in Whooping-Cough.

AMONG those who are so unfortunate as to suffer from sea-sickness, one of the favourite methods of relief is the application of pressure over the stomach. There is no doubt that this lessens the tendency to continued vomiting, and the same principle has been applied with some success in the vomiting of pregnancy. More recently, Dr. Kilmer, of New York, has introduced the use of an abdominal elastic belt in the treatment of whooping-cough. He employs an elastic bandage reaching from the axillæ to the hips, keeping it slightly on the stretch. Underneath the elastic he first applies a stockinette binder to protect the skin. The results, both as regards cough and vomiting, are most satisfactory. In only one case out of eighteen did he fail to stop the vomiting, while in one-third of the cases the cough was either greatly lessened or stopped. That the sequence of events was really causal was shown by the recurrence of the cough and vomiting in one case when the belt was removed by the child's mother. The method is so simple in its application, and so entirely harmless, that it will doubtless receive a wide trial, and it may possibly prove of some use in the treatment of a troublesome condition.

#### Anæsthesia in Operations on the Naso-Pharynx.

THERE are certain surgical operations which, on account as well of their brevity as of their site, form, as regards the choice of a suitable anæsthetic, a class by themselves. These are the brief operations on the mouth, nose, and throat which rarely require more than two minutes' time available for work. Such are many dental operations, and such operations on the throat as removal of tonsils or adenoid growths and snaring of polypi. It is necessary in most of these cases for the anæsthetist to produce at the start a sufficient anæsthesia to carry the surgeon through the whole operation. When induction has been made, the anæsthetist removes his apparatus and

hands over the patient to the surgeon. Under the circumstances, great discrimination is necessary in the choice of an anæsthetic, and it is obvious that this will be governed by quite different considerations from those that obtain in other cases. Until recently chloroform has been on the whole the favourite agent, and there is no doubt that as regards quiet anæsthesia, freedom from irritation of the larynx and absence of coughing, it gives excellent results. It presents, however, the serious disadvantage that it can never be given in safety to a patient in the sitting posture, an attitude chosen by many surgeons, and that in any case it introduces the risk of sudden syncope. Nitrous oxide, while a perfectly safe anæsthetic agent, rarely gives the desirable quietude, and it gives an awkwardly brief anæsthesia. Mr. Luke, of Edinburgh, who has a large experience of anæsthetic work of this class, is inclined to leave the choice finally between ether and ethyl chloride. While the former is very constant in its action, it sometimes produces cyanosis with troublesome bleeding, and induces cough with consequent collection of mucus at the site of operation. Ethyl chloride, on the other hand, gives a calm and comfortable anæsthesia which by an adroit administrator can be made to last up to four minutes, though so long a time is rarely required. In addition, the patient recovers very quickly, and is seldom annoyed by vomiting or other troublesome sequelæ. On the whole, it would seem that ethyl chloride, either alone or in the mixture known as "somnoform," is the most suitable agent in this class of cases.

#### Folk-Medicine in Fife.

THE study of folk-medicine is not merely one of those hobbies, interesting and amusing, which add zest to the life of a medical man working in a country district. It is, if properly considered, a valuable contribution to historical psychology, exhibiting those peculiarities of point of view and of belief which are the remnants of a mental attitude of a much earlier era. Most items of folk-medicine as they are found at present belong in origin to one of two classes. They are on the one hand, charms, incantations, or sacrifices directed to the appeasement of gods or demons, or, on the other, crude precepts empirically derived. These latter, being judgments from experience, do not differ in kind from the practices of legitimate medicine, but merely in the degree of their scientific justification. In many customs, of course, the propitiatory idea and the judgment of experience are inextricably blended, and, indeed, the latter is always put forward as the ostensible reason of the practice. Dr. Rorie, of Fifeshire, in a recent collection (a) gives many interesting customs observed in his neighbourhood. A case of sacrificial cure is that of the application of three puppy dogs, split up and applied hot, to a septic arm. Though the animal varies, this custom has been noted practically all over the

world. A curious remedy for enuresis is the broth or powder made from boiled or roasted mice. A decoction of black slugs is a cure for rheumatism, and the juice of white slugs for phthisis. As in many other localities, the smell of fresh-turned earth is regarded as possessing peculiarly beneficial power, and miners suffering from exposure to impure air were made to lie with the face over a fresh-cut hole in the earth. If Dr. Rorie were not a good Scot, we should think he was poking fun at the good people of Fife when he tells us of the horror with which they regard "a rash drink o' water," and their belief in the various dangers which follow the incautious use of that dangerous and insipid fluid.

#### Aerophagy.

EVERY "horsey" man knows that one of the worst tricks a horse can learn is that known as "wind-sucking," or the swallowing of air, which, though not fraught with serious consequences, leaves the horse in unfit condition for violent exercise. Mathieu has recently drawn attention to a similar habit which exists in the human race, although the persons afflicted are rarely aware of the condition. In fact, they think that air is passing in the opposite direction, and they may complain of eructations. In the act of air-swallowing, the patient closes his lips, bends his head forward, and makes a swallowing movement, and if at the time the stomach be auscultated an explosive ringing sound is heard as the bubble enters it. If large quantities of air be swallowed, considerable distension, of course, occurs, until relief is given by a violent eructation. In fact the habit seems sometimes to spring from the attempt to produce this result. Where there is a moderate degree of flatulent dyspepsia, for instance, discomfort is relieved by the belching of wind, and swallowing of air may be a necessary antecedent of this act. Mathieu distinguishes several types of aerophagy, of which the most important are the dyspeptic and the hysterical. In the latter condition, enormous quantities of air may be swallowed quite silently and unconsciously, and may only become felt by the ensuing flatulence and tympanitis.

#### The Heart in Tuberculosis.

SINCE the announcement by Rokitansky, in 1846, of the theory of the supposed antagonism between valvular heart disease and pulmonary tuberculosis, many observers have sought to bring forward clinical evidence in its favour. It is generally believed that valvular disease affecting the left side of the heart has a more or less retarding influence upon the progress of chronic phthisis, or even that individuals so affected are to some extent exempt from the attacks of the tubercle bacillus. The explanation which has been offered for this antagonism is that a sort of immunity is conferred through the venous

(a) *Edin. Med. Journ.*, June, 1904.

stagnation and consequent chronic congestion which is maintained throughout the pulmonary circulation. That this "immunity" is by no means absolute, nor, indeed, constant, is proved by the fact that the concomitance of the two affections not infrequently occurs. Dr. G. A. Norris, (a) of Philadelphia, has found that smallness of the size of the heart, which was at one time thought to be an important predisposing cause of tuberculosis, is generally discovered at the post-mortem; but he considers that this may be equally the result of the generally impoverished condition of all the bodily tissues. On the other hand, patients suffering from pulmonary stenosis are exceedingly prone to contract phthisis, and this is not surprising when it is borne in mind that this particular cardiac lesion is frequently associated with congenital abnormalities which do not improve the general poorly aerated condition of the blood. Actual tuberculosis of the heart itself is decidedly rare, but it has been estimated that some degree of tuberculous endocarditis is met with in something under 5 per cent. of all cases of phthisis submitted to an autopsy. Degeneration of the cardiac muscle commonly occurs in pulmonary tuberculosis, which probably accounts for the failure of digitalis in many cases of phthisis.

#### The Influence of Attention upon Work.

As a state of consciousness, attention is psychologically considered to be that condition in which a single idea is predominant over all others. Active attention necessarily implies concentration of the whole mind upon the matter in hand, and without this no true mental impression can be made. Read in this light the popular phrase of "giving one's mind to one's work" has a deep psychological significance. The inattentive child, whose thoughts are instantly diverted by the buzzing of a fly or the patter of raindrops upon a window-pane, can no more hope to master his lesson than the student who habitually allows his mind to run off on side issues. Lack of concentration is fatal to success, especially in matters scientific, where secrets can be learnt only by steady and patient application. However desirable or attractive the quality of versatility, it must be kept under control by all who would seriously contribute to the sum of human knowledge. Many individuals of undoubted genius, of high mental qualities, are unable to undertake original research, simply because they cannot focus their undivided attention upon one topic. It is true, of course, that certain purely mechanical work may be performed practically without attention, as may be seen in the case of a pianist carrying on a conversation with a friend. But although manual work may be to a large extent independent of voluntary attention, it is also far better performed when directed and accompanied by mental processes. This fact has recently been scientifically confirmed by M. Féré, who, by taking ergographic records, has found that the working

capacity of the middle finger for weight-lifting is considerably impaired if the attention be concentrated upon some other part of the body. We have, therefore, a physiological basis for the Ciceronian dictum—"Quicquid agas, agere pro viribus."

#### Craniotomy.

A GOOD deal of discussion has been going on in various countries lately as to the performance of craniotomy on living children. In Protestant countries the view generally held is that there should be no hesitation in sacrificing the child's life if thereby the mother can be saved, whilst Roman Catholics are inclined to attach greater importance to the child's existence. In modern midwifery, though craniotomy is still much in vogue in delivering a child already dead, there is a considerable change in practice with regard to living children, now that Cæsarian section and symphysiotomy can be performed with such good prospects to both subjects. Whilst prepared to spare no effort to bring a living child into the world, most obstetricians would hardly go so far as to say with Pinard that embryotomy of the living child is a thing of the past. Strict surgical practice will, however, generally find itself in accordance with the moral dictates of the question, and the effort to spare both lives is usually made. How seldom embryotomy is necessary if skilled attendance is at hand is shown by the results of Veit's practice in the towns of Leiden, Erlangen, and Leipsic. In eight thousand deliveries conducted under his supervision he has never once had recourse to it, and he holds that it can always be avoided if the diagnosis of the obstructive condition is made sufficiently early. Veit has performed Cæsarian section twenty times, and symphysiotomy six times in his series of cases; and the fact that he has only lost two mothers and two children compares very favourably with the usual mortality results attached to embryotomy. Even those who are not prepared to agree with Veit, that embryotomy is never called for, cannot but congratulate him upon his success.

#### The Medical Diplomates of Scotland.

THE newly-formed Association of medical men holding one or more of the various diplomæ of the Scotch Colleges is the latest of the many bodies that have sprung up in the medical profession of late years. It has been formed mainly with an eye to the interests of practitioners in parts of the Kingdom other than Scotland, where it may be presumed that there is no need for protection. Medical practitioners holding these particular qualifications form a strong body in England, Wales, and Ireland. One of their chief grievances lies in the fact that they are excluded from the honorary staff appointments at most of the large hospitals, Metropolitan as well as provincial, outside Scotland. In London a flagrant example is to be found in the person of an accomplished assistant surgeon who, after

(1) *Amer. Journ. Med. Sci.*, October, 1904.

twenty years' service, was kept out of the full surgeoncy because he did not hold an English qualification. A similar injustice is repeated again and again in many a provincial town and country hospital. Subscribers to medical charities cannot be expected to understand the slur they cast upon honourable men by enforcing restrictions worthy of a trades union rather than of a liberal profession. It is to be hoped that the new Association will succeed in throwing open all hospital appointments to Scotch, and, incidentally, also to Irish Diplomates. Among its Vice-Presidents are Professor Clouston, Sir Patrick Heron Watson, Sir J. Halliday Croom, Sir Alfred Cooper, Sir James Clark, Sir Anderson Critchett, Sir John Reed, Sir John Sibbald, Sir John Tyler, and Sir William Whitla. Full information as to the objects and proposed work of the Association may be procured from the energetic Honorary Secretary, Mr. Heather Bigg, F.R.C.S., 56 Wimpole Street, London, W.

#### PERSONAL.

THE health of the Prince of Wales at the end of last week formed the subject of detailed sensational statements in certain newspapers, the editors of which have not hesitated to assert that consumption was detected some years ago in the Royal patient by Sir Frederick Treves—a surgeon, by the way—just before the Prince's voyage in the *Ophir*. The rumour—on the face of it ridiculous—has been already officially contradicted.

SIR WILLIAM MITCHELL BANKS, M.D., F.R.C.S., of Liverpool, who died in August last, has left estate of the gross value of £23,527 11s. 2d., including net personally sworn at £21,642 19s. 5d. By his will, dated July 5th, 1887, his widow is appointed sole executrix.

At a recent meeting of the Australian State Cabinet, Dr. W. E. Jones, superintendent of the Brecon and Radnor Asylum, was appointed Inspector-General of the Asylums for the Insane in Victoria.

DR. H. E. SCOWCROFT has resigned the appointment of District Surgeon of Raub, Pahang, Federated Malay States.

DR. J. M. RHODES, Chairman of Committee, recently laid the foundation stone of the buildings of the Colony for Sane Pauper Epileptics at Langton, near Blackburn, the first of its kind established in the United Kingdom.

THE President of the Seventh French Medical Congress, recently held in Paris, was the famous pathologist and histologist Professor Cornil.

At the French Congress one of the most important communications was that of Professor Chantemesse on "The Serum-therapy of Enteric Fever," by which method he claimed to have reduced the mortality to 1 per cent.

THE new Belfast Maternity Hospital was opened on Monday, November 7th, by the Countess Grosvenor.

THE winter session inaugural address of the Royal Medical Society of Edinburgh was delivered on October 28th last by Sir James Crichton-Browne.

At a meeting on November 1st, of the Faculty of Medicine of the University of London, Mr. Butlin delivered his valedictory address on his retirement from the office of Dean, a position which he resigns by

virtue of a rule that limits the period of office to four years.

DR. JAMES KINGSTON-FOWLER was, at the same meeting, unanimously elected to the important post of Dean of the Faculty of Medicine of the University of London.

MR. A. PEARCE GOULD was at the same time elected Vice-Dean of the Faculty.

DR. P. H. PYE-SMITH has been reappointed representative of the University of London on the General Medical Council.

MR. FRANCIS GALTON, F.R.S., has endowed a Fellowship in the London University for the promotion of the study of eugenics, defined as "the study of the agencies under social control that may improve or impair the racial qualities of future generations, either physically or mentally."

ON St. Luke's day last, October 18th, Sir John Banks, K.C.B., attained his sixtieth year of Fellowship of the Royal College of Surgeons of Ireland. Although Sir John has for some years retired from active participation in the affairs of the College, he still takes a keen interest in its welfare. At the meeting of the College held on Friday last a resolution of congratulation on the occasion of the diamond jubilee of his election to the Fellowship was carried by acclamation.

SIR CHARLES BALL, F.R.C.S., has resigned the office of representative of the Royal College of Surgeons in Ireland on the General Medical Council. We are informed that Mr. Swanzy, whose name as an ophthalmic surgeon is well known, and who is the present vice-president of the College, and Sir Thomas Miles, ex-president of the College, have offered themselves as candidates for the office.

DR. CECIL SHAW has been appointed lecturer on ophthalmology and otology in the Queen's College, Belfast, in succession to the late Dr. McKeown. Dr. Shaw already holds the posts of Assistant-Surgeon at the Belfast Ophthalmic Hospital, and of Ophthalmic Surgeon to the Mater and Ulster Hospitals.

PROFESSOR LORRAIN SMITH, who is leaving Belfast to take up his appointment at the Victoria University, Manchester, was on Thursday last presented by his colleagues and friends with a handsome souvenir at a complimentary dinner, particulars of which will be found in the letter by our Belfast correspondent.

WE learn that the teaching duties of the Chair of Surgery in Trinity College, of which Professor Bennett has been relieved, have been committed to Mr. Edward H. Taylor, F.R.C.S.I., Examiner in Anatomy to Dublin University, and Surgeon to Sir Patrick Dun's Hospital.

PROFESSOR WINDLE's resignation of the Birmingham chair of anatomy was formally communicated to the council of the University at its last meeting, when the following resolution was unanimously passed:—"That the Council receives the resignation of Dr. Windle with regret, and, while congratulating him on his important educational and administrative appointment in Ireland under the Crown, takes the opportunity of thanking him for his long and distinguished services to the School of Medicine in Mason College and to the Medical Faculty of this University, both as dean and as professor, as well as to the general cause of higher education in the Midlands."

#### Harvelian Society of London.

THE annual dinner of the society will be held at the Monico Restaurant on Thursday, November 24th, at 7 for 7.30 p.m. The chair will be taken by the President, Dr. C. Theodore Williams.

## Special Correspondence.

FROM OUR OWN CORRESPONDENTS.]

### SCOTLAND.

GLASGOW OPHTHALMIC INSTITUTION.—On the 1st inst. a course of post graduate lectures and demonstrations was inaugurated by Dr. A. Maitland Ramsay, who delivered an instructive address on "Eye-strain and its Consequences." The lecture was illustrated by means of lantern-slides, microscopic preparations, the opaque projector, and by Kuhne's optical box. Mr. Hedderwick, the chairman of managers of the Glasgow Royal Infirmary, presided, and expressed his gratification at the large attendance of medical men, as showing that the Institution was not only an agent for the relief of suffering, but was also fulfilling an educational purpose in the City.

### BELFAST.

COMPLIMENTARY DINNER AND PRESENTATION TO PROFESSOR LORRAIN SMITH.—A farewell dinner to Professor Lorrain Smith, on the occasion of his leaving Queen's College, Belfast, for Victoria University, Manchester, was held in the Grand Central Hotel, Belfast, on Thursday evening, November 1st. The President of Queen's College presided, and practically all Dr. Smith's late colleagues at the College and at the Royal Victoria Hospital, Belfast, were present, as well as many of his past pupils and lay friends. After the usual loyal toasts the President proposed the toast of "Our Guest." In doing so, he contrasted the state of pathological teaching in Belfast ten years ago, when Dr. Smith was appointed, and now, when, thanks to the munificence of the late Sir James Musgrave, they had an endowed professorship, and through the joint action of the Government and the college, a proper building had been provided, with rooms for lectures, research, &c., and modern appliances. No small share in these changes was, he said, due to Professor Lorrain Smith, who had also made that laboratory an ultimate court of appeal on medical questions from all Ulster. The Civic authorities, too, had availed themselves of Dr. Smith's services, and he had been called in as an expert in various difficult questions regarding the prevalence of typhoid, the contamination of water, and the disposal of sewage. President Hamilton also referred to Dr. Smith's help on the College Council, the Victoria Hospital, and on the examining board of the Royal University, and concluded by wishing him all success in the new sphere to which he was going.

The toast having been enthusiastically honoured, Dr. Smith, in reply, explained that the founding of the School of Pathology had only been possible by the greatest self-sacrifice on the part of the other teachers of the medical school, for the funds at the disposal of the school were so small that the necessary money for outfit and upkeep could only be got by stinting other departments. In spite of that, the new department was administered in no grudging spirit, and never a word of complaint reached him. To the men in the college who spent their lives working for their departments, and whose lifework was being crippled by the absence of funds, he wished to make on that occasion the fullest and heartiest acknowledgment. But for their self-sacrifice and public spirit the medical school would that day have been without anything worthy of the name of a pathological department. It was a matter of pride to him that during his term of office about one hundred post-graduate students passed through the department, and a number of them stayed to work at research as long as their time permitted.

Dr. R. J. Johnstone then presented Dr. Smith with a solid silver tray, on which was inscribed: "To Professor Lorrain Smith, from his old friends and pupils at the pathological laboratory, Queen's College, Belfast, 1895-1904." He explained that this was not from the medical profession generally, but just a souvenir from some of the men who had enjoyed many happy hours of work, tempered by the fumes of tobacco, in the laboratory. Dr. Johnstone dwelt specially on the

research work carried out by Dr. Smith's pupils, and the enthusiasm with which he fired them, and the way in which the school acquired under his guidance a character of its own. As an instance, he mentioned Dr. Houston's work on the pathology of the blood.

Dr. Smith, in reply, thanked his old friends and pupils very warmly, and dwelt on the happy fellowship of the laboratory workers all through his time at the college. The first worker with him had been Dr. Cecil Shaw, whom he was glad to congratulate on his recent appointment on the College staff, as lecturer on ophthalmology. Others, too numerous to mention by name, had followed, and many continued to work during all the time he was there. He had the utmost pleasure in receiving the handsome piece of plate, and thanked them all for the kind sentiments expressed on their behalf by Dr. Johnstone.

APPOINTMENTS TO THE ROYAL VICTORIA HOSPITAL. The following appointments have been made at this hospital: Drs. Crymble, Davis, and Killen to be house surgeons; Dr. Lowry to be house physician; Dr. McIlwaine to be medical registrar; Dr. Irwin to be surgical registrar; Dr. H. Stevenson to be hon. anaesthetist; and Dr. Beattie to act as temporary pathologist to the hospital.

## Correspondence.

### THE TREATMENT OF INOPERABLE CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Had Dr. Mackenzie read my letter a little more carefully he would have seen that I was claiming nothing, and it was therefore unnecessary for him to say that he did not wish to deprive me of any credit. All I desired to do was to correct the impression which you, Mr. Editor, and others had received, that he was the pioneer in the treatment of cancer of hypodermic injection. I do not agree with the correctness of the statements in Dr. Mackenzie's letter; but I need not trouble you with such trivial matters except to say that I do not know why Dr. Mackenzie appears to be so annoyed with me, as I gave him full credit for his work with Merck's iodipin on the only occasion I published anything on the subject. It is, however, necessary to refer to Dr. Mackenzie's last sentence in which he asks me "in justice to himself and others," to publish now what I was using nearly two years ago. Why in justice to him I cannot imagine, as he already knows what I was experimenting with, but his curiosity will perhaps be gratified when I tell him that at present I am experimenting with arsenic. It would never occur to me even to think of publishing with only the support of two cases, one dead and the other—nature of tumour apparently not diagnosed—under treatment for less than two months! Besides, I do not wish to run the risk of having an objectionable advertisement in one of the Sunday papers as Dr. Mackenzie has had to put up with. My brother and I have had better results at the beginning of more than one experiment, and when Dr. Mackenzie has had a few more unsuccessful cases he will not be so ready to publish what he hopes, but will wait until he knows. In this work one may hope for success, but must expect disappointment. There have been too many "cures" lately—salt, molasses, violets, Schmidt, mulyptol, &c., and I regret that Dr. Mackenzie is trying to add to their number on such very insufficient grounds. Doctors understand the value of such evidence, but readers of the *Dispatch* do not.

I am, Sir, yours truly,

GEORGE E. KEITH.

7, Manchester Square, W., Nov. 4th, 1904.

### THE LACK OF PRACTICAL METHODS IN SURGICAL TEACHING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am glad to see that Mr. Edmund Owen does not feel well pleased with the present state of things in the practical work of our medical schools and education. Nowadays many men are beginning to find out that the system that has grown up during the past

forty years or so is not satisfactory. To what extent they have to thank themselves for this we can leave them to consider. There is one thing quite certain, and that is they did nothing to stop it. There has been no proper clinical teaching in our hospital schools, and specialism has been preferred.

The consequences are beginning to be felt, and it is well for those who find fault to look to what they did themselves to prevent. Mr. Edmund Owen and many like him let things go in a good-tempered, indifferent way, and now they deservedly suffer.

I am, Sir, yours truly, R. L.  
Kensington, Nov. 1st, 1904.

#### MUNICIPAL DENTISTRY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is impossible to deny the fact that at the present day a considerable proportion of children of every class display signs of dental degeneration, and that among the poor these signs, as well as the presence of decayed teeth, are more common; but, statistics having been accumulated only within recent years, and this to a partial extent only, there exists no scientific basis whatever for the opinion that dental deterioration is extending or that dental caries is more prevalent among the present than former generations. It seems a little grotesque to read that in St. Petersburg nine municipal dental institutes have been set up, whilst the population throughout Russia is allowed to live in sanitary surroundings worse than Oriental, and to suffer from periodical preventable famine with epidemic diseases due to filth and want. It will be not much less ludicrous if we in England follow this example before setting to work to remove the first causes of the evil, and to apply remedies which shall result in production of a race showing physical superiority in every direction, including the teeth. In this way it would pay better first to establish municipal dairies where the poor could obtain milk up to a high standard of quality and purity. Rickets, one of the commonest causes of tooth decay, is largely due to lack of proper food in the way of milk. In many municipalities, especially where tradesmen dominate the local authority, the Food and Drugs Acts are either very slightly attended to, or altogether ignored; and the poor are supplied with milk of the most inferior quality. Reform of these abuses is more urgently called for than municipal dentistry. The housing question, the question of educating poorer class mothers in elementary knowledge of hygiene and the feeding of infants, and many other questions of the same kind, all under discussion at the present moment, and all bearing upon the subject of physical deterioration—all these questions call for attention and solution before provision of municipal dentistry is brought to the front. The question of providing meals for ill-fed school-children, which has lately been dealt with in an important correspondence in the *Times*, seems also somewhat more urgent than municipal dentistry. Money is needed for coercion of neglectful parents, and perhaps for provision of food and cooking arrangements at the schools. To starving children good teeth are not the most urgent necessity. Municipal dentistry is not more urgently called for than—for one example out of fifty—municipal hair-cutting and head cleansing. I could name a village in Surrey at this moment in which the majority of the children are affected with ring-worm, which prevents them from attending school. This has spread so widely in consequence mainly of the foul and often verminous conditions in which the unkempt heads of the children are habitually left by their careless parents. Many of these children are suffering from adenoids and chronic nasal catarrh caused in great measure by the damp, dark and unwholesome dwellings in which they are lodged. If local governing bodies are to spend more money, it ought surely to be on matters of prime importance, not upon grandmotherly projects such as municipal dentistry.

I am, sir, yours truly,

HENRY SEWILL.

## Obituary.



MR. HERBERT WILLIAM ALLINGHAM, F.R.C.S. ENG.

TELEGRAPHIC information has been received from Marseilles announcing the death by misadventure, on the 4th inst., of Mr. Herbert William Allingham, F.R.C.S., of 25, Grosvenor Street, London, while on his way to Egypt for the benefit of his health. He was the eldest son of the eminent surgeon, Mr. William Allingham, F.R.C.S., who is still living, and was born on April 17th, 1862. After receiving his education at Chatham House School, Ramsgate, and University College School, London, he entered as student at St. George's Hospital, where, at the time of his death, he held the position of Senior Assistant Surgeon and Lecturer on Operative Surgery. He became M.R.C.S. Eng. in 1882 and F.R.C.S. in 1887. In 1889 he married Fraulein Alexandrina von der Osten, who died in January of the present year. Her death was most keenly felt by him, and the breaking down of his health dates from this bereavement, from the effects of which, he confessed to the writer of these lines a short time since, he was quite unable to free himself, and the profession which he had loved and pursued with so much enthusiasm had ceased to possess the same interest for him. His professional career was one of exceptional brilliancy, and his reputation as an operator of great skill and judgment was world-wide. He held the position of Surgeon to the Household of his Majesty the King when Prince of Wales, and was subsequently appointed Surgeon to the Household of his Majesty the King. He was also Surgeon in Ordinary to his Royal Highness the Prince of Wales, and one of the Honorary Surgeons to King Edward VII.'s Hospital for Officers. Mr. Herbert Allingham was formerly surgeon to the Great Northern Central Hospital, and assistant surgeon to St. Mark's Hospital for Fistula. He was the author of several valuable works, that on "Diseases of the Rectum" having reached the seventh edition, and his



new work on "Operative Surgery," has proved a distinct success. He had also in the press another brochure on "Appendicitis."

The untoward death of Herbert Allingham from an overdose of morphia in the zenith of his professional career will come as a profound shock to the medical world as well as to a large and distinguished circle of friends. Although a young man he had already years ago achieved brilliant success whether judged from social or professional standpoints. Following in the footsteps of his father he early specialised in the direction of rectal surgery. His book on the "Diagnosis and Treatment of Diseases of the Rectum" has become a classic. He made numerous other important contributions to medical literature, and was a member of various learned societies. By his death the profession has been deprived of one of the most brilliant surgeons of the younger generation.

#### MEETING OF THE GENERAL MEDICAL COUNCIL.

We are officially informed that the Autumn Session of the General Medical Council will be held at the Office of the Council, at 2 p.m., on Tuesday, 22nd inst., and following days, at which Sir William Turner, K.C.B., will preside.

#### Literature.

##### HAMILTON ON "RAILWAY AND OTHER ACCIDENTS." (a)

THIS much-needed book supplies a gap in medical literature, and, moreover, fulfils that function in an effective fashion. The author has written for lawyers as well as for medical men—two professional classes that require special information on the matter of real and imaginary and pretended disorders of traumatic origin. The subject is, of course, a complicated one. The interests of the plaintiff as well as of the defendant must, of course, be protected. The shock of a railway accident, moreover, may upset the mental balance of a sufferer, and so inflict one of the many remote injuries for which a railway company may be called upon to make compensation. A finer degree of partial mental injury may present a knotty point for protracted legal discussion. We heartily endorse the author's position when he says:—"The time has certainly come for some one who is initiated, and has sufficient knowledge to urge the proper and honest presentation of medical facts in Court by the plaintiff as well as by the defendant, for it does not do to pervert medical truths, which in their way are quite as settled as the axioms of law." The absolute necessity of special knowledge and caution can be gathered from the experience of an English physician in over two hundred alleged railroad injuries. Of these thirty-two were frauds or cases of wilful exaggeration, twenty-one substitution cases in which there was a history of gout, phthisis, chronic epilepsy, alcoholism "female diseases," or conviction of previous ill-health; six women alleged that the symptoms of the menopause were due to injury; three had been in previous accidents, seven were the subjects of fright or suggestion, and one case of glycosuria was attributed to an accident, but was shown to be of previous origin; and in another old syphilis was made to do duty; in one case, in which insanity was claimed to be the result of an accident, it was proved to have antedated it. In forty-four there is a history of "no exaggeration," or the patient made a moderate claim; of the above cases, therefore, it will be seen that in at least two-fifths there was a suspicion of fraud. This is the best book we have seen on the subject, and it must at once take a high place of authority and reference.

(a) "Railway and Other Accidents." By A. M. Hamilton, M.D., late Clinical Professor of Mental Disease in Cornell Cottage Hospital, &c., &c. London: Baillière and Cox. 1901. Price 5s. net.

##### TEXT-BOOK OF CLINICAL ANATOMY. (a)

By the time the student has reached the study of clinical medicine and surgery, his anatomical acquisitions, cumbered as they too often have been by details which have little practical bearing, are apt to be relegated to the garret of his mental equipment, and the fact that in his ward work he receives instruction in "medical" (not to speak of "surgical" and "gynæcological") anatomy tends to lead him to divorce the systematic knowledge he has so laboriously acquired from everyday work, while when his memory requires refreshing he too readily tends to refer to some convenient diagram in a book on clinical diagnosis rather than wade through the pages of an anatomical text-book, seeking for the grain of information among an intolerable heap of, to him, now useless facts. That this is not as it should be is daily more and more being recognised by anatomical teachers, who now pay much greater attention to applied and topographical anatomy than, say, a decade ago, and the volume now before us is an expression of this. The author has essayed, and to a large extent succeeded, in giving a complete presentment of the main facts of clinical anatomy, surgical and medical, within a comparatively reasonable compass. No doubt the anatomist might find errors of detail or slight descriptive inaccuracies, but from the clinician's standpoint the volume is almost wholly satisfactory. Dr. Eisendrath naturally pursues the regional method, and in each section tells the student what he can feel with his fingers and see with his eyes, before proceeding to describe deep structures and their relations. We note with satisfaction that throughout the book sufficient attention is paid to the anatomical peculiarities of the child. The rather dry bones of anatomy are partially, at least, clothed and resuscitated by references to clinical symptoms and pathology generally, and while we admit the importance of this in giving a live interest to the pages of facts, we are not sure but that the size of the book might have been reduced without affecting its usefulness by a judicious curtailment, both of these clinical details and of some of the short descriptions of operations. The illustrations throughout maintain a high level of merit, but here again the pathological ones, few as they are, might for the most part have been omitted without any great loss. We had hoped to find greater use made of radiographs. A few plates showing the ossification of some of the chief epiphyses at different ages, for example, could readily have been obtained, and would have given information which generally requires a good deal of search when it is wanted. Another omission which strikes us is the inadequate space given to the anatomy of the nervous system; there is, for instance, no drawing of the base of the brain—one to which a student often wishes to refer—and cerebral topography in general is scantily dealt with. Assuredly the student will not get enough anatomical information to be of service in the diagnoses of nervous cases from Dr. Eisendrath. When a second edition of the book is called for, as we are sure it will be, we trust that space, which could easily be got by a judicious condensation of the pathological information, will be found to rectify the omissions referred to, when the student will have in one volume a most convenient work of reference to which he will rarely turn in vain.

##### NEW BOOKS AND NEW EDITIONS.

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

- THE ABERDEEN UNIVERSITY PRESS, LTD. (Aberdeen).  
University of Aberdeen—Proceedings of the Anatomical and Anthropological Society, 1902-1904. Illustrated. Pp. 155.  
EDWARD ARNOLD (London).  
Lectures on Diseases of Children. By Robert Hutchison, M.D., F.R.C.P. Pp. 338. Price 8s. 6d. net.  
ASHER AND CO. (London).  
St. Louis, 1904. German Educational Exhibition. Medicine. Pp. 169.

(a) "A Text-book of Clinical Anatomy." By Daniel M. Eisendrath, Professor of Clinical Anatomy in the University of Illinois Philadelphia: W. B. Saunders and Co. 1904. 21s. net.

- BAILLIÈRE, TINDALL AND COX (London).**  
 Handbook of Diseases of the Ear. By Richard Luke, F.R.C.S.Eng. Second Edition. Illustrated. Pp. 242. Price 6s. net.  
 The After-Treatment of Operations. By Lockhart Mummery, F.R.C.S.Eng., B.A., M.B., etc. Second Edition. Illustrated. Pp. 240. Price 5s. net.  
 The Nutrition of the Infant. By Ralph Vincent, M.D. Second Edition, revised and enlarged. Pp. 321. Price 10s. 6d. net.  
 Guide to the Examination of the Throat, Nose, and Ear, for Senior Students and Junior Practitioners. By William Lamb, M.D., C.M.Édin., etc. Illustrated. Pp. 152. Price 5s. net.  
 Malignant Diseases of the Larynx (Carcinoma and Sarcoma). By Philip R. W. De Sauti, F.R.C.S. Pp. 107. Price 4s.  
 Aids to the Study of Sanitary Law. By Harry Critchley, M.A., M.D., D.P.H., etc. Pp. 82. Price 2s. 6d., cloth, 2s. paper.  
 Burden Camels; Their Management and Diseases. By H. M. Lenox-Conyngham, Capt. A.V.D. Pp. 24. Price 1s. 6d. net.  
 Transactions of the Medico-Legal Society for the Years 1902, 1903, and 1904. Edited by Stanley B. Atkinson, M.A., M.B., Vol. I. Pp. 100. Price 7s. 6d.
- JOHN BALE, SONS AND DANIELSON, LTD. (London).**  
 Medical Hints and Notes on Egypt as a Winter Resort. By Arthur J. M. Bentley, M.D. Pp. 43. Price 1s.  
 Notes on Assouan. By G. Dundas Edwards, M.A., Camb., M.R.C.S., etc., etc. Pp. 36. Price 1s. net.
- JOHN BEVAN AND SONS (Torquay).**  
 Letters on Health and Happiness. By John A. Bevan, M.D., Pp. 68. Price 2s. 6d. net.
- ARCHIBALD CONSTABLE AND CO., LTD. (London).**  
 Clinical and Pathological Observations on Acute Abdominal Diseases. By E. M. Corner, B.Sc., Lond., etc., etc. Pp. 98. Price 3s. 6d. net.  
 The Surgery of the Diseases of the Appendix Vermiformis and their Complications. By Wm. Henry Battle, F.R.C.S., and E. M. Corner, M.B., etc., etc. Pp. 208. Price 7s. 6d. net.
- J. AND A. CHURCHILL (London).**  
 Urine Examination Made Easy. By Thomas Carruthers, M.A., M.B., Ch.B. Pp. 32. 1s. 6d. net.
- CORNISH BROS. (Birmingham).**  
 On the Sterilisation of the Hands. By Charles Leedham-Green, M.B., F.R.C.S. Pp. 102. Price 2s. 6d. net.
- CHARLES GRIFFIN AND CO., LTD. (London).**  
 Text-book of Human Physiology. By Dr. L. Landois. Fifth Edition. Illustrated. Pp. 1027.
- H. K. LEWIS (London).**  
 Medical Electricity: A Practical Handbook for Students and Practitioners. By H. Lewis Jones, M.A., M.D. Fourth Edition. Illustrated. Pp. 536. Price 12s. 6d. net.  
 Deaths in Childbed; A Preventible Mortality. By W. Williams, M.A., M.D., etc. Pp. 99. Price 2s. 6d. net.
- LONGMANS GREEN AND CO. (London).**  
 The Essentials of Chemical Physiology. By W. D. Halliburton, M.D., F.R.S. Fifth Edition. Pp. 236. Price 4s. 6d. net.
- FRANK F. LISIECKI (New York).**  
 The Surgical Treatment of Bright's Disease. By George M. Edebolis, A.M., M.D., etc. Pp. 327.
- THE LONDON ARGUS LIBRARY OF FICTION (London).**  
 A Sparrow, a Mouse, and a Man. By George H. R. Dubbs, M.D. Pp. 68. Price 6d.
- LONDON COUNTY COUNCIL (London).**  
 The Fifteenth Annual Report of the Asylums Committee and the Sub-Committees for the year ending March 31st, 1904. Pp. 230. Price 2s.
- MACMILLAN AND CO., LTD. (London).**  
 The Food of the Gods and How it Came to Earth. By H. G. Wells. Pp. 217. Price 6s.
- GEORGE FITMAN AND SONS, LTD. (London).**  
 The Blind Man's World; An English Version of Entre Avengles. By Dr. Emile Javal. Translated by W. Ernest Thomson, M.A., M.D. Pp. 158. Price 3s. net.
- REBMAN, LTD. (London).**  
 The Diseases of Women. By J. Bland-Sutton, F.R.C.S.Eng., and Arthur E. Giles, M.D., etc. Fourth Edition. Illustrated. Pp. 520. Price 11s. net.
- ST. ANDREW'S AMBULANCE ASSOCIATION (Glasgow).**  
 Home Nursing and Hygiene. By J. Wallace Anderson, M.D., and George H. Edington, M.D. Pp. 156.
- W. B. SAUNDERS AND CO. (Philadelphia).**  
 A Text-Book of Clinical Diagnosis by Laboratory Methods. By L. Napoleon Boston, A.M., M.D. Illustrated. Pp. 549. Price 18s. net.
- SUDAN GOVERNMENT (Khartoum).**  
 First Report of the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum. By the Director, Henry Balfour, M.D., B.Sc., etc. Pp. 88, with Coloured Plates.
- TAYLOR AND FRANCIS (London).**  
 Calendar of the Royal College of Surgeons of England, August 1st, 1904. Pp. 350.
- UNIVERSITY PRESS (Liverpool).**  
 Liverpool School of Tropical Medicine; Memoir XIII. Reports of the Trypanosomiasis Expedition to the Congo, 1903-1904. By J. E. Dulton, M.B.; J. L. Todd, M.D.; and C. Christy, M.B. Pp. 112.
- JOHN WRIGHT AND CO. (Bristol).**  
 An Introduction to Dermatology. By Norman Walker M.D. Illustrated. Pp. 284. Price 9s. 6d. net.

### Laboratory Notes.

#### B. EUCAIN LACTATE (SCHERING.)

A PREPARATION manufactured by Messrs. Schering of Berlin, at the suggestion of Professor Langgaard, to take the place of eucaïn and cocain. It combines the advantages of the low toxicity associated with eucaïn with a high degree of solubility—up to 29 per

cent. in water at room temperature. B. eucaïn lactate is a white non-hygroscopic powder very readily soluble in hot water; less so in cold. The eucaïn base in this salt is somewhat less than in the ordinary B. eucaïn; thus slightly stronger solutions are necessary. The London agents are Messrs. A. and M. Zimmermann.

#### THE SCHLEUSSNER X-RAY PLATES.

WORKERS with the X-rays are always on the look-out for a good plate, which, when found, is a treasure indeed. We have been asked to test the Schleussner plates, and have much pleasure in stating that for all-round X-ray purposes they are as good as any that have come under our notice. At the same time the price is not excessive, a drawback that applies to several sensitive plates specially introduced for this special kind of work. We have tried the Schleussner plate with various developers, and personally have obtained the best results with ordinary "pyro" developer, with which we have obtained beautifully modulated but clear pictures. The excellent illustration which appeared on page 460 of THE MEDICAL PRESS AND CIRCULAR (November 2nd, 1904) was taken on one of these plates, which are placed on the market by Messrs. Christy and Co., and may be purchased from the usual vendors of photographic plates. We should advise all radiographers to give them a trial.

#### MESOTAN.

A NEW salicylic remedy for the external treatment of rheumatic affections has been introduced by the Bayer Company. The remedy is mixed with an equal quantity of olive oil and brushed on the affected part several times daily. It is said to relieve pain and have a curative effect upon all pain of a rheumatic origin. The success obtained by Continental authorities with Mesotan certainly warrants an extensive trial by medical men in the United Kingdom. It is described by the manufacturers as a substitute for gaultheria oil, but it has a far less pronounced odour and is of greater facility of absorption.

### Medical News.

#### The 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 28th ult. There were present Dr. de Havilland Hall, in the chair; Dr. Walter Smith, Dr. M. Greenwood, Mr. F. S. Edwards, Dr. W. Knowsley Sibley, Dr. A. J. Rice Oxley, Mr. H. P. Symonds (Oxford), Dr. Fredk. S. Palmer, Mr. Edwd. Bartlett, Dr. J. Brindley James, Dr. St. Clair R. Shadwell, Dr. F. J. Allan, Dr. J. W. Hunt, and Dr. J. B. Ball. The amounts showed a great improvement in the sickness claims, which were unusually heavy in the early part of the year. Since June the amount paid away has been appreciably under the expectation, and there is little doubt that the whole year's working will show a good margin in favour of the Society. On the other hand the general depression in business which has been somewhat severely felt by many members of the medical profession, shows itself in the lowered numbers of new members joining the Society. The last two years have been exceptionally good in this respect, and there is no reason to fear that as soon as the present temporary depression has passed away the social advantages to be obtained by joining the Society will not induce a large number to join it. Prospectus and all information on application to Mr. F. Addiscott, secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

#### Central Midwives Board.

At the last meeting of this Board (a report of which appeared in our last issue) a scheme of examinations was adopted of which the following are the most important provisions:—A list of examiners, subject to annual revision by the Board, 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. Examinations will be partly oral and practical, and partly written, and shall be conducted by not fewer than two examiners. The first examination will be held in July, 1905, and future examinations four times a year, or oftener if necessary, in London and the provinces, simultaneously on the same papers. The first provincial centres are to be Bristol, Manchester, Newcastle-on-Tyne. The remuneration of an examiner is fixed at the rate of seven shillings for each candidate examined. The scheme further provides that 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, and that 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 shall, in respect of this duty, 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. From these regulations it appears that the principal duty of the provincial examiners is to set examination questions, and that these questions are to be then censored by the London examiners, and presumably, if thought suitable, are then to be made use of. We confess that we are unable to understand how any provincial obstetrician of repute could accept the post of examiner under such conditions. It may, be, however, that the regulations given above are capable of another interpretation from that which the phraseology necessitates.

#### Royal Ear Hospital.

THE new premises of the Royal Ear Hospital in Dean Street, Soho, are now completed, and the out-patient department is in full swing. With regard to out-patients special care has been taken on the one hand to secure the comfort of the patients, who are seen singly, and on the other to provide the surgeons with every modern up-to-date contrivance both for diagnosis and for operative and general treatment. The in-patients' department, which will shortly be opened, consists of three wards, one for children, one for women on the first floor, and one for men on the second floor. Alongside the latter is the operating theatre, which boasts of capital natural light, and is, of course, replete with all the necessary appliances of modern surgery. The children's ward has a high dado, which, dealing with nursery rhymes, should have a most soothing effect on the little sufferers. This hospital, which claims to be the oldest institution for the special treatment of aural and allied diseases, not only in this country but in Europe, was originally founded as far back as 1816 in Dean Street, Soho, under the name of Royal Dispensary for Diseases of the Ear; in 1876 it migrated to Frith Street, and in 1883 the Committee opened a department for in-patients. It is computed that upwards of 150,000 patients have received advice and treatment at the institution since its foundation.

#### Irish Medical Schools' and Graduates' Association.

THE autumn general meeting of this association will be held at the Hotel Cecil, Strand, on Tuesday, November 22nd, at 6.30 p.m. The autumn 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, Surgeon-General C. Sibthorpe, C.B., in the Chair. The hon. secretaries will be glad to forward forms of application for membership to members who may have friends to propose for election to the association. New members joining on November 22nd may attend the dinner.

#### Royal College of Surgeons in Ireland.

THE lectures of the Winter Session commenced on Tuesday, November 1st. The prizes of the previous

session were distributed by Mr. Arthur Chance, president, as follows:—

*Barker Anatomical Prize*—£31 10s., C. Cooper.

*Mayne Scholarship*—£15, A. N. Crawford.

*Carmichael Scholarship*—£15, J. Preadiville.

*Gold and Silver Medals in Operative Surgery*.—Gold, J. S. Dunne; silver, P. D. Sullivan and J. C. Murphy (equal).

*Stoney Memorial Gold Medal in Anatomy*.—J. Preadiville.

*Descriptive Anatomy—Junior*.—D. P. Clement, first prize (£2) and Medal; G. S. Levis, second prize (£1) and certificate. *Senior*.—D. Adams, first prize (£2) and Medal; P. G. M. Elvery; second prize (£1) and certificate.

*Practical Anatomy—First Year*.—G. S. Levis, first prize (£2) and medal; D. P. Clement, second prize (£1) and certificate. *Second Year*.—P. G. M. Elvery, first prize (£2) and medal; T. A. Buchanan; second prize (£1) and certificate.

*Practice of Medicine*.—R. Bury, first prize (£2) and medal; P. D. Sullivan; second prize (£1) and certificate.

*Practical Histology*.—H. C. Carden, first prize (£2) and medal; D. Adams, second prize (£1) and certificate.

*Practical Chemistry*.—R. H. F. Taaffe, first prize (£2) and medal; F. C. Warren, second prize (£1) and certificate.

*Public Health and Forensic Medicine*.—M. Cohen, first prize (£2) and medal; T. H. Massey, second prize (£1) and certificate.

*Materia Medica*.—F. C. Warren, first prize (£2) and medal; J. B. Kelly, second prize (£1) and certificate.

*Biology*.—J. C. S. Day, first prize (£2) and medal; T. C. Boyd and H. W. White (equal), second prize (£1) and certificate.

*Surgery*.—J. S. Dunne, first prize (£2) and medal; R. Bury and F. Lyburn (equal) second prize (£1) and certificate.

*Midwifery*.—J. S. Dunne, first prize (£2) and medal; R. A. Browne, second prize (£1) and certificate.

*Physiology*.—D. Adams, first prize (£2) and medal; T. Sheehy, second prize (£1) and certificate.

*Chemistry*.—D. P. Clement, first prize (£2) and medal; A. E. S. Martin, second prize (£1) and certificate.

*Pathology*.—L. Lucas, first prize (£2) and medal; P. D. Sullivan, second prize (£1) and certificate.

*Physics*.—A. E. S. Martin, first prize (£2) and medal; W. G. Ridgway, second prize (£1) and certificate.

#### The Tottenham Hospital Dinner.

A FESTIVAL dinner in aid of the funds of the Tottenham Hospital was held at the Savoy Hotel, Strand, on November 2nd, 1904, under the presidency of Lord Burnham, a large and influential company being present. In the course of his remarks from the chair, Lord Burnham sketched the growth of the institution from its foundation, and pointed out the immense work which was being done by the hospital, situated as it was in the midst of a densely-populated portion of North-East London. He referred to one of the cherished treasures of the institution—an autograph letter from the late Empress Augusta—which bore testimony to the splendid work performed by the Tottenham Hospital Sisters in the Franco-German War, nor was the high standard lowered in the present day. All that was now required was further extension of the building. Sir Francis Cory-Wright (chairman of the Hospital Committee) announced that operations would not be delayed much longer, as tenders for the building were to be received shortly. The Secretary (Mr. F. W. Drewett) then read out, amid cheers, the stewards' lists, which amounted to £4,002 10s. Mr. John Langton responded on behalf of the medical staff, and Dr. Percy Kidd proposed the health of the chairman.

## 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.

**UNIQUE.**—The coroner has absolute power in the matter, and as the presiding judge of his court he directs the jury as he pleases—occasionally, it happens, but very rarely that the jury returns a verdict contrary to his opinion.

### THE DIMINISHING BIRTH-RATE.

A Neo-Malthusian writes calling our attention to the close connection which he maintains is to be found between the land monopoly and the diminishing birth-rate. In reply we can only say it seems likely that anything that unduly increases the cost of living must necessarily make it more difficult to rear families, and hence to make parents disinclined to procreate children. In making this general admission we express no opinion as to the pros and cons, of so-called land monopoly, and the special laws affecting that class of property and the absence of taxation of ground values are somewhat outside the scope of a medical journal. The diminishing birth-rate, however, is clearly enough a fitting subject for medical discussion. It is, however, highly complex and raises issues that can be adequately dealt with only by a consideration of the social, the medical, the political, the statistical, and the economic circumstances of the case.

**BEDFORD.**—Our advice is to take no further notice of the claim, but should another acrimonious letter be received the correspondence had better be placed in the hands of a solicitor, or referred to the Medical Defence Union, if our correspondent happens to be a member of that useful society.

### FEIGHT OF FEAR ILLNESS.

A Correspondent, referring to our annotation on this subject congratulates us on "this singularly timely article in view of the severe attack of 'funkitis' from which the Baltic Fleet is suffering at the moment"; and suggests that we "should send a specially marked copy of the current number to his majesty the Czar, and another to Admiral Rozhdestvenski, care of Admiral Togo."

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 9th.

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

**SOUTH-WEST LONDON MEDICAL SOCIETY** (Bolingbroke Hospital, Wandsworth Common).—9 p.m. Paper:—Dr. W. W. H. Tate: "The Diagnosis and Treatment of Tubal Gestation in the Early Weeks."

**HUNTERIAN SOCIETY** (London Institution, Finsbury Circus, E.C.). 9 p.m. Lecture:—Dr. B. Bradford: "The Treatment of Bright's Disease."

**MEDICAL GRADUATES' COLLEGE and POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. E. W. Roughton: "Clinique (Surgical)." 5.15 p.m. Mr. F. C. Wallis: "Injuries to and Diseases of Joints."

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (North-Eastern Fever Hospital, St. Ann's Road, N.).—2.30 p.m. Dr. H. Cuff: "Demonstration on Feveris."

**CENTRAL LONDON THROAT and EAR HOSPITAL** (Gray's Inn Road W.C.).—5 p.m. Demonstration:—Dr. Wylie: "Naso-Pharynx."

THURSDAY, NOVEMBER 10th.

**BRITISH GYNECOLOGICAL SOCIETY** (20 Hanover Square, W.).—8 p.m. Papers:—Dr. Maccaughton-Jones: "Embedded Adnexa. Carcinoma of Fallopian Tube, Hemorrhagic Endometritis."—Dr. B. Fenwick: "Uterine Fibroids associated with Ovarian Disease. Adjourned Discussion on Mr. C. Martin's paper on the Treatment of Severe Protrusion by Extirpation of the Uterus and Vagina."

**OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM** (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens will be shown by Mr. Doyne and Mr. Stephenson. 8.30 p.m. Paper:—Mr. S. Snell: "Intraocular Tumour covering the Optic Disc."

**MEDICAL GRADUATES' COLLEGE and POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: "Clinique (Surgical)." 5.15 p.m. Dr. W. Ewart: "The General Management and Special Methods of Treatment of Heart Cases."

**MOUNT VERNON HOSPITAL FOR CONSUMPTION and DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture:—Dr. G. Johnston: "Aortic Aneurysm (illustrated by cases)." (Post-Graduate Course.)

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Mr. H. W. Carson: "Middle-Ear Carcinoma."

FRIDAY, NOVEMBER 11th.

**THE INCORPORATED SOCIETY OF MEDICAL OFFICERS OF HEALTH** (9 Adelphi Terrace, Strand, London, W.C.).—7.30 p.m. Paper:—Dr. G. A. Baron: "Instruction in Hygiene in Universities and Schools—a Proposal."

**BRITISH LARYNGOLOGICAL-RHINOLOGICAL and OTOLOGICAL ASSOCIATION** (Medical Society's Rooms, 11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Council Meeting. 4 p.m. Exhibition of Cases, Specimens, and Instruments. 4.15 p.m. General Meeting. Presidential Address. Dr. Horne: "Pachydermia Laryngis."

**POST SANITARY ASSOCIATION** (Westminster Palace Hotel—11 noon. Meeting.

**CLINICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—8 p.m. Paper:—Mr. C. R. Keyser: "A Case of Congenital Elevation of the Scapula."—Dr. P. D. Turner and Mr. E. Johnson: "Traumatic Axillary Aneurysm successfully treated after Extravasation had occurred by Proximal Ligature."—Mr. B. Robinson and Mr. E. M. Corner: "Aneurysm of the Intracranial Part of the Left Internal Carotid caused by a Bullet Wound through the Right Eye."—Mr. S. Page: "A Case of Appendix Abscess followed by Abscess in the Left Iliac Region."

**MEDICAL GRADUATES' COLLEGE and POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Dr. St. Clair Thomson: "Clinique. (Throat.)"

## Vacancies.

**Peckham House Asylum.**—Second Assistant Medical Officer. Salary £150 per annum. Applications to the Resident Licenses, Peckham House, Peckham, S.E.

**Birmingham City Asylum, Rubery Hill, near Birmingham.**—Junior Assistant Medical Officer. Salary £150 per annum, with board &c. Applications to the Medical Superintendent.

**Manchester Jewish Hospital.**—Resident Medical Officer. Salary £20 per annum. Applications to Secretary, Jewish Hospital, Cheetham, Manchester.

**Braecliffe Asylum, near Lincoln.**—Junior Assistant Medical Officer. Salary £126 per annum, with furnished apartments, &c. Applications to W. T. Page, jun., Solicitor and Clerk to the Visiting Committee, 5 Bank Street, Lincoln.

**St. Mary's Hospital, Oxford Street, Manchester.**—House Surgeon and Resident Obstetric Assistant Surgeon. Salary £100 per annum, with board and residence. Applications to the Secretary, University of Birmingham (Faculty of Medicine).—Professor of Anatomy. Salary £200 per annum. Applications to Geo. H. Morley Secretary.

**Royal Berkshire Hospital, Reading.**—House Physician. Salary £80 per annum, with board, lodging, and washing. Applications to the secretary.

**Royal Dental Hospital of London, Leicester Square.**—Patron: His Majesty the King.—Dental Superintendent. Salary £250 per annum. Applications to J. Francis Pink, Secretary.

**Fisherton House Asylum, Salisbury.**—Medical Superintendent. Salary £400 per annum, with board, lodging, and washing. Applications to Dr. Finch, Salisbury.

**County Asylum, Mickleover, Derby.**—Junior Assistant Medical Officer. Salary £120 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

**Leicester Infirmary.**—House Surgeon. Salary £100 per annum, with board, apartments, and washing. Applications to Harry Johnson, House Governor and Secretary, the Infirmary, Leicester.

**Royal Portsmouth Hospital.**—Senior House Surgeon. Salary £100 per annum, with board, residence, &c. Applications to J. S. Neil, Secretary.

**Catholic University of Ireland.**—Joint Professor of Anatomy. Applications to the Registrar of the Medical School. (See Advt.)

## Appointments.

**AARONS, S. JERVOIS, M.D. Edin., M.C.C.P. Lond.,** Pathologist and Curator of the Museum Hospital for Women, Soho Square, W.

**BRADSHAW, THOMAS E., M.D. Dub., F.R.C.P. Lond.,** Examiner in Medicine in the University of London.

**BROCKBANK, F. M., M.D. Vict., M.R.C.P. Lond.,** Junior Physician to the Children's Hospital and Dispensary, Manchester.

**BUCHANAN, P. S., M.B. Glasg.,** in Charge of the Out-door Midwifery Department of the Glasgow Public Dispensary.

**BURNEY, C. D. FRANCIS, M.R.C.S.,** Divisional Surgeon to the E Division Metropolitan Police (Deptford), and also Divisional Surgeon to the police stationed at Deptford Victualling Yard (Woolwich Division).

**COUTTS, E. N., M.B. Toronto, L.R.C.P. & S. Edin.,** Resident Physician to the Royal Infirmary, Glasgow.

## Births.

**BLUMER.**—On November 4th, at St. Mary's Grove, Stafford, the wife of F. Milnes Blumer, M.B., of a son.

## Marriages.

**MACNAMARA—JERMAIN.** On November 5th, at Nazira Assam, India, John Radley Macnamara, F.R.C.S.(I), Medical Officer, Assam Compy, to Natalie Maude, youngest daughter of Captain Jermain, E.N., of the Cottage, Orondall, Hants.

## Deaths.

**ALLINGHAM.** On Nov. 5th, at Marseilles, Herbert W. Allingham, F.R.C.S., of 25 Grosvenor Street, London. Aged 42.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, NOVEMBER 16, 1904.

No. 20.

## Original Communications.

### THE VARIOUS PHASES OF A HOSPITAL'S WORK. (a)

By SIR C. J. NIXON, M.D.,

Physician to the Mater Misericordiarum Hospital, Dublin.

AFTER some introductory remarks dealing with the past history of the hospital, and a reference to the loss it had sustained by the death of Mr. Patrick Hayes, its senior surgeon, Sir Christopher Nixon said that it was in regard to the utilisation of the hospital for the purposes of research that his address was especially concerned, and he asked his hearers to bear with him whilst he endeavoured to put forward this claim as strongly as he was able. The progress of hospital work, he continued, in its relation to the prevention and treatment of disease may be said to be slow and uneventful until the time of Lister. It is true that physicians like Addison and Jenner made record discoveries by pursuing cases of disease from the clinical standpoint to the *post-mortem* room, and no doubt many interesting problems in the biology of disease were made clear by these and other observers. But the stimulus to laboratory investigation dates from the discovery of Lister, who utilised to the fullest extent the labours of Pasteur. That discovery was altogether the result of his observations in hospital, for nowhere except in a large general hospital could he have found materials for that method of treatment which has revolutionised not merely surgery, but the medicine of our day. As an illustration of the effect of the Listerian treatment of wounds, I believe I am correct in stating that the mortality after major operations has been reduced from 40 to 3 per cent.

Who can estimate the gain to humanity of the result of this one instance of hospital research work? It is almost entirely to research work undertaken in the laboratory that pathology may be said to have attained its present position. A comparatively few years ago the work of the pathologist was left to the assistant medical officers—indeed, largely to the senior students. There existed, no doubt, in an imperfectly organised form, the machinery for recording notes and compiling facts in connection with the biology of disease, of comparing these with conditions found after death, and for making generalisations from both data. But there were no means of pursuing inquiries into the modes of origin of disease, nor was any attempt made to determine the nature of obscure conditions which could only be investigated by the use of instruments of precision not then employed. In Dublin in 1894 the first step was taken in the United Kingdom to place pathology in its legitimate position. The Royal University, at the instigation of Sir William Thomson and myself, made the regulation that pathology and bacteriology should be made a special subject of the medical curriculum, and, at the same time, a professorship was created in the Medical School of the Catholic

University, and the professor was appointed pathologist to the hospital. Since then the clinical physician and surgeon have had the advantage of his services. Those who are familiar with the work of the clinician can fully appreciate how much it is bound up with that of the pathologist. In many cases not merely does the diagnosis of the existing morbid condition depend upon the report furnished from the laboratory—a report most frequently made as a result of some bacteriological or chemical investigation—but the line of treatment to be pursued is based upon the conditions which this investigation has determined. There is no difficulty in realising why this should be. The physician studies the disease almost exclusively from its biological aspect; the pathologist in addition investigates it, with all the modern instruments of precision at his hand, from the physical, chemical, and bacteriological standpoint. In many, if not most, cases it is impossible to divorce the two methods of observation; hence the clinician and the pathologist may be regarded as the complement of each other. Let me illustrate my meaning by an example. There is frequently considerable difficulty in diagnosticating between two severe forms of anæmia, a profound chlorosis and progressive pernicious anæmia. There are no special signs or symptoms by which the physician can distinguish one from the other, and it is only when the blood has been subjected to a physical and chemical examination that a correct conception of the existing condition can be formed—a conception which carries with it the knowledge of the life or death of the patient.

But the work of the physician and pathologist does not stop here. The case of chlorosis is quite clear. Employing the known remedies, the patient, almost as a matter of certainty, recovers. But quite different is the case of pernicious anæmia, in which the accuracy of the diagnosis is attested by the inevitable death of the patient. Since Addison and Biermer drew attention to the condition in 1867 a great deal has been learned in connection with the disease and with the changes produced by it in the various organs and tissues of the body. But as yet the primary condition which produces the blood change is unknown. We are unable to say whether it is caused by some chemical disturbance which interferes with cell nutrition and so disturbs the uniform composition of the blood, or by some ferment or toxin which affects the vitality of the blood-cells and leads to their excessive destruction. How are these obscure points to be cleared up? As yet every form of treatment of the disease has proved futile because of our ignorance of the primary disturbance of health. It is only by carefully noting each case under observation, observing every sign indicative of functional and organic disturbance, experimenting with medicines that favourably influence the course of the affection, and, above all, employing the physical, chemical, and bacteriological methods of investigation at our disposal that we shall be able to solve the mystery that at present envelopes the origin of the disease. Such a condition is quite as hopeful for solution as was myxœdema but a few years ago. The clinical investigation of this disease led us to recognise a blood state which reduced the patient to almost a condition of imbecility; was capable of being produced by a removal of the thyroid

(a) An Address delivered at the opening of the Winter Session of the Mater Misericordiarum Hospital, Dublin.

gland, whilst further investigation established the identity of the disease with cretinism, the condition represented by those deformed and stunted specimens of humanity which the traveller meets with among the inhabitants of Switzerland and northern Italy. After a certain stage the steps of inquiry passed beyond the domain of the clinical observer, and the work of investigation was undertaken by the chemist and experimental pathologist. The brilliant results obtained by Horsley by removing the thyroid gland in monkeys, and the adoption of a line of treatment suggested by him and Murray of supplying thyroid gland substance to animals and human beings in which the gland was absent is perhaps an instance of as great a triumph of the art of medicine as it is possible to record. Not alone is the cretinoid condition removed in adults, but even cretins, those creatures who seemed so little removed from mere animal existence, became bright and intelligent, and, if treated at an early age, had their bodily growth and normal configuration restored. I dwell upon this condition because it affords an illustration of what the experimental mode of investigation is likely to lead to. It would be altogether beyond the scope of this address to advert at any length to what has been achieved by experimental research, or to state in detail how much mankind owes to it in connection with the treatment of diphtheria, tetanus, rabies, and in the investigations of the various diseases caused by parasitic micro-organisms. It is this method which, in the study of immunity, has led to the artificial production in the blood of those substances, toxins which will, without doubt, protect the individual against the poison of typhoid fever, pneumonia, the deadly tubercle bacillus, and perhaps from that dread disease, cancer. When we consider how many morbid conditions there are in which there is the most intimate knowledge of the functional disturbance and organic changes which exist—where the biological history is carefully compared with the changes noted after death, and where only one link is wanted to explain the disturbed mechanism—one can realise how limited in usefulness would the clinical observer be if he were content merely to register his failures, and make no attempt to solve the riddles that daily present themselves. Let me mention some common instances of disease, the obscurity of whose origin still remains to be solved. We are all familiar with the symptoms and signs of diabetes, of the pathological changes produced by it, but we are yet in absolute ignorance of the initial point of departure from normal function. A similar difficulty presents itself in exophthalmic goitre, every symptom-complex of which has been made the subject of detailed and elaborate investigation. Subtle nervous conditions—like paralysis agitans, chorea, and epilepsy are yet inexplicable as to their mode of origination. We cannot presume to more than theorise upon their etiology. In pneumonia and acute rheumatism we are equally in doubt. We do not know the conditions which in the one disease make the individual a suitable host for the pathogenic micro-organism, whilst in the other we are unable to determine whether a chemical agent or a microbe sets in motion the morbid state. It would be easy to multiply instances of disease, of the common forms of disease, in which we physicians have to play the rôle of empirics as regards treatment, and in which this humiliating position of empiricism must largely predominate until some advanced degree of certainty is reached by an accurate knowledge of the true nature of the morbid condition; but until that time comes I am afraid we must in many cases be content to accept humbly the old definition of a physician, that he is a satisfaction to the mind of a patient. The public are not given, even granting this mental capacity, to analyse the methods of investigation and treatment employed in any case of disease. An individual has some particular ailment, and he wants to get cured of it. There is not much use explaining to him that we are not as

yet certain of the way in which the disturbance of his health is set up, and that his condition can be only dealt with symptomatically. We may talk to him very learnedly, and look more wise than even a physician could really be, but the patient tells you he came to be cured, and he expects you to work a miracle on his behalf. Such an instance is an answer to the distinguished physicist who some days ago addressed the students of a London hospital. He very truly pointed out that the fundamental studies of medicine were of a strictly materialistic nature, that they belonged to a different world from that which constituted the main object of a student of medicine, and that we should not deal with living men and women as if they represented a mere physical mechanism, as mere laboratory or chemical specimens. But, unfortunately, as we know nothing of the problem which constitutes life, we have no other methods of analysis of processes of disease except by noting physical and chemical phenomena, and comparing these in any given case with a normal standard, and that normal standard is one that is conditioned by the principle of life. What is meant to be conveyed by the lesson is that we are not to regard our patients as merely a piece of very fine mechanism, constructed by a skilled artificer, which will not bear rough or unintelligent interference, but as a type of the most supreme specimen of delicate structure endowed with the unknown principle of life, and therefore to be dealt with on a plane apart from ordinary physical and chemical methods of investigation. I venture to consider this line of argument may be considered to be what is known as a *sciomachy*, a battle with a shadow. Where, I ask, is there the slightest ground for believing that a single thought or act in connection with the sufferer in any hospital is not associated with his well-being, and in what instance is there any advance of knowledge that is not utilised for his benefit? In all obscure cases it is our duty to unravel the web, and in doing this by the finite means at our disposal we are steadily pressing onward to the goal which marks the limit of human progress in medicine. It is only in this way we may hope to satisfy those who come to us for relief.

And here I think it my duty to freely acknowledge the thoroughly progressive spirit in which the Sisters of Mercy have administered the affairs of this hospital, their readiness at all times to accede to the recommendations of the Medical Board in all matters which are essential to the welfare of the patients and of the institution generally, and to their never-failing consideration and courtesy towards both the staff and the students.

It was this spirit of progress which impelled those responsible for the management of the hospital to provide the necessary facilities for the carrying on those researches which will lead to our more accurate knowledge of disease and its treatment. They have provided us with a laboratory which, under the direction of the pathologist of the hospital, Professor McWeeney, will be utilised for the progress of the science and art of medicine. Professor McWeeney will be glad to show our visitors over the laboratory and explain to them the points of interest in connection with it. Upon him will rest a great responsibility, the charge of the pathological department of a great hospital, and I will only say of him that I believe him to be intellectually fitted for the post. There is a remarkable point worthy of notice in connection with the pathological department of the hospital. The Royal University grants studentships in two subjects of the medical curriculum—physiology and pathology. The pathological studentship is awarded every alternate year, and since its foundation five studentships have been awarded. Out of these five, four have been gained by former students of the hospital—the first by our own professor, Dr. McWeeney; the second by the distinguished assistant physician of St. Vincent's Hospital, Dr. Dargan; and the third by Dr. Curran, the assistant surgeon to this hospital; and the fourth



by Dr. Denis Farnin. Much, it is hardly necessary to say, is expected from a triumvirate representing such brilliant attainments.

The encouragement given by the managers of the hospital to the employment of scientific methods of investigation of disease necessitated an encroachment upon its slender resources. But the enlightened spirit which provided those facilities for research is bound to have its reward in perfecting our means of combating disease and alleviating human suffering. To me, personally, the opening of a new laboratory is an occasion of extreme interest. I have been connected with the hospital for thirty-six years; I have noticed its steady development and progress, and now, in the forty-third year of its existence, it may be said to be entering upon a new career of usefulness. It has, as you are all aware, an intimate connection with the Catholic University School of Medicine, and I venture to express a hope that the bond between the two institutions will be even more strongly cemented in the future. A great school of medicine—and the Catholic University School, with all its drawbacks as to position, structural proportions, and lack of endowment, can claim to be by far the largest school in Ireland, a distinction which many will regard as of some importance—should be in the closest relation with a great hospital, so that the research work of each would be facilitated and augmented. In this way the tone and status of medicine in Ireland would gradually reach the level of that attained by the great Continental schools. There should be no hesitation in accepting this view. Before the introduction of the modern methods of precision in the diagnosis of disease the Dublin school was, in many instances, in advance of the great schools in Germany, France, and Austria. Graves, Collis, Corrigan, Stokes, and Adams constitute a quintette of original observers, each one of whom is handed down to posterity as the discoverer of the special disease which bears his name. But just as the sister country has fallen so much behind in all scientific work, and as her industries have been to a large extent monopolised by America and Germany, so medicine in Ireland has not held its own in research. Yet it may be asked, is there any quality of brain power in Ireland which, under favourable conditions, would prevent it from successfully competing with that of the Germans or the French? To have signal results I hold you must have a combination of a great hospital with a great school. Given a completely equipped school of medicine, having each department thoroughly organised, manned by a competent staff of professors and assistants, and collaborating its work with a great hospital, which the spirit of the time has made ideal in all its departments, then I do not say I believe, but I feel confident, the genius of Irishmen will make their country a home for scientific progress in medicine. It is scarcely possible to conceive, with the encouragement that is being given to the various conditions bound up with industrial and agricultural life in Ireland, and with such indications as are presented of the dawning of prosperity and progress, that no consideration will be given by the State to a profession from which it extracts so much profit. I say this notwithstanding that the opportunity which was recently afforded to the Government of settling the University question in such a way as would provide a school of medicine commensurate with the requirements of students of the country at large was not, unfortunately, availed of. The report of the Royal Commission on University Education in Ireland appears likely to share the fate of most Royal Commissions, the reports of which, so far as Ireland is concerned, result in vitalising the conditions they were appointed to remedy. It is stated that the present Government has fallen back no less than 34 times on Royal Commissions, at a cost to the country of £392,000. In Ireland we have had several, and in most of them the outcome was uniform—no result. Indeed, in connection with higher education in this

country, one would feel inclined to urge the friends of the University of Dublin to demand the appointment of a Commission to consider the present condition of the higher, general, and technical education available in Ireland inside Trinity College, Dublin. No matter what the Commissioners report, it is almost a certainty that the *status quo* will be maintained, and the University will be able to repeat MacMahon's response at Malakoff—" *J'y suis, j'y reste.*" Still, if a comment may be made upon the recent report on University Education presented to his Majesty, it is not to say that, prepared as we may be for the policy of *laissez faire* which, in regard to Ireland, appears to be a characteristic of our Government, still, one would hope there is a limit which no self-respecting Government would outstep in dealing with a country which it professes to govern, and with a body of men to whom it entrusted an almost sacred mission. The condemnations and recommendations of the Commissioners are so destructive in their nature that in face of them to maintain an institution which, in the words of the Act establishing it, was to promote the advancement of learning in Ireland, appears to be "a mockery, a delusion, and a snare." The three main findings of the Commission were that the Royal University lowered the ideal of University education, that its system of making appointments to the Senate and offices of the University was indefensible, and that the system adopted by it of indirectly endowing certain colleges must be condemned. It is scarcely conceivable that no action would be taken upon this report, coming from a body of experts appointed by practically the same Government which abolished the Queen's University and substituted in its place the Royal University, or that any Government would be so inconsiderate, to say the least, as to continue to impose upon the members of the Senate the duty of administering the affairs of an educational body which was the subject of so strong a censure. Or is its policy to be represented by the lines—

"I see the right, and I approve it, too;  
Condemn the wrong, and yet the wrong pursue" ?

There must be some change effected, and with the change I hope will come the realisation of my ideal—a great and thoroughly equipped school and hospital bound together by the closest bonds of union, and working for the common object, the progress of our profession.

In connection with the question of Commissions, appointed to redress Irish grievances, I should like to advert briefly to one which for the moment excited keen interest amongst the hospital charities of Dublin. In March, 1885, a memorial from the Medical Board of this hospital was presented to the then Lord Lieutenant, Earl Spencer, praying that an inquiry should be held into the conditions, as regards work done, and the management of each hospital in Dublin, with a view to a redistribution of the Parliamentary grant annually voted for the maintenance of some of these hospitals. The prayer of the memorial was acceded to, and in April, 1887, a Commission was appointed to make inquiry into the management and working of the hospitals in the city, the conditions upon which annual grants from the public funds were given for the support of certain hospitals, and whether any redistribution of such annual grants was expedient and advisable. The Commissioners sat for a period extending over some five months, and examined 86 witnesses, from whom valuable information was obtained upon all points in connection with hospital management, none more valuable than that given by my colleague, Mr. Chance, the President of the College of Surgeons. The Commissioners, seven in number, unanimously signed a report which made, amongst others, the following important recommendations:—  
(a) That the annual grant should be commuted for a capital sum, to be invested in the names of trustees, and the interest thereon should be paid to a central

board to be distributed by them to such hospitals as should fulfil certain specified conditions. (b) The conditions laid down to entitle any hospital to a share in the distribution of the grant referred to the number of beds occupied, the number of students attending clinical instruction, the number of nurses and probationers trained, the general efficiency of the institution, and the energy of the directors, as evidenced by the amount of money collected in the shape of private subscriptions, donations, and bequests. I would not be justified in saying that the report gave universal satisfaction, but I believe I am within the strict limits of truth in stating that the feeling which prevailed amongst members of the profession and of the public generally was that a solution eminently fair and practical had been arrived at, and that, with due regard to vested interests, the recommendations of the Commissioners would be given effect to. This view was confirmed by the course taken by the Government of the day, for in August, 1889, a Bill giving effect to all the proposals specified in the report of the Commission was introduced by Mr. Jackson, the Chief Secretary for Ireland for the time being. And now occurred an action of a mysterious nature. For some cryptic reason—there never was the least attempt to explain the why or wherefore—the Bill, after being read a second time, was withdrawn, and the report of the Dublin Hospital Commission shared the fate meted out to the many Commissions which preceded and followed it. I would hardly think it necessary to touch upon this matter but for the dim shadows that are appearing heralding the advent of some fiscal arrangement by which all Irish moneys will be dealt with by a purely Irish Executive. If this should come about, whether by "devolution" or some more advanced and more stable scheme of reform, I should hope the demand for equitable consideration of each hospital in Dublin will be complied with.

I have only to add a few words to the students of what I am justified in calling a national institution. This hospital, if developed on the lines indicated in my address, cannot but be ultimately associated with the progress of medicine in Ireland. It may be that some of those whom I have the pleasure of addressing may play an active part in rendering it a pioneer in the advancement of that knowledge which is essential to the well-being of our race. With the most striking evidences presented to us of the almost illimitable powers of man's productiveness in every department of physical science, especially during the latter half of the century just passed, in which the record of wonders appears to have been reached, it is not likely that the science of medicine will stand still. There are indications that we are moving in the direction of some great discoveries in connection with the prevention and treatment of disease which will be no less startling than those of the physicist and chemist, with this distinction—that whilst they deal with material substances, our lot concerns alone the well-being of our own species—man. Our profession is not one that brings either ease or wealth in its train. To the vast majority of those who embrace it as a calling there is but little beyond a well-earned competence. But with its many drawbacks it has within it elements of human interest which contrast favourably with the sordid and debasing elements of other pursuits. We certainly, in our profession, have a great incentive to live up to Sydney Smith's noble ideal—Let every man be occupied, and occupied in the highest employment of which he is capable, and die with the consciousness that he has done his best.

#### The Royal University of Ireland.

HIS MAJESTY'S Royal Warrants have been received appointing Rt. Hon. Lord Killanin, Sir William Thomson, C.B., M.D., and Dr. Bertram C. A. Windle, President of Queen's College, Cork, to be members of Senate.

## THE STERILISING OF SURGICAL DRESSINGS. (a)

By A. SCOT SKIRVING, M.B., C.M., F.R.C.S. Ed.,  
Assistant Surgeon, Royal Infirmary, Edinburgh.

SOME eighteen months ago, in considering the cause of an operation case becoming septic, Mr. Skirving had investigated the subject of sterilisation of dressings by the ordinary methods in vogue, in particular by the Schimmelbusch-Lautenschläger steriliser and drum. Though much had been written on the subject of sterilising the skin, the hands of the surgeon, catgut ligatures, &c., there was not very much recent literature on the treatment of surgical dressings, and this had led the writer to consider the whole question. Passing from the simple and trustworthy methods of sterilising by boiling and immersion in antiseptic solutions, the most generally used means, that of steam sterilisation, had to be considered. There were three difficulties in sterilising in this way:—First, as to the steam itself; second, the steriliser; and third, the drum. The first of these difficulties, the kind of steam which it was best to employ, was the greatest, involving, as it did, abstruse questions of thermo-dynamics. The following terms were applied to steam:—Steam in equilibrium, steam in motion, steam under pressure, steam not under pressure, saturated steam, and superheated steam. Ambiguity often arose in using the two last expressions. Saturated steam was steam carrying a certain amount of water in suspension, its temperature, of course, depending on the pressure. As long as this steam remained in contact with the water from which it was produced, its temperature was the same as that of the water. Once away from the water, however, its temperature might be raised without altering its pressure, and steam so treated was said to be superheated. If saturated steam were mixed with water at the same temperature, none of the water was evaporated; if superheated steam were employed in the same way some water was evaporated. The greater the extent to which steam was superheated, the more did it assume the properties of a gas. It was important to surgeons to know that saturated steam had far more sterilising power than superheated steam, as Braatz and Esmarch's researches showed. For example, anthrax spores were killed in five minutes by saturated steam at 100°, but survived superheated steam at 110° for thirty minutes, and at 120° for twenty minutes. Now, a number of sterilisers and disinfectors avowedly made use of superheated steam, especially those in which no circulation of steam takes place, and in which steam is admitted externally for warming purposes at a higher pressure and temperature than that in the interior of the apparatus. Further, it was probable that superheating took place accidentally in a fair number of sterilisers in which this was not included—e.g., some small sterilisers with steam only at 100° C., and not under pressure, if preliminary warming of the dressing is carried out before the steam is admitted. To avoid this, fore-warming ought not to be allowed to exceed 60°. As to the question of steam under pressure, but not superheated,

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society, November 2nd, 1904.

experiments conclusively proved that its bactericidal power was enormously increased when the pressure was raised. It was, of course, questionable whether laboratory organisms were exactly comparable to those growing in wounds as regards their power of resistance; and it seemed as though different strains of cultivated organisms varied somewhat in their powers of resistance. Next, as to the question of air in sterilisers. Air, as was well known, was a feeble germicide, and it was a serious menace to effective sterilisation if the air in the apparatus was not completely expelled, as when the lower tap was, through carelessness or accident, not opened at the commencement of the operation. He had made a number of experiments on the temperature in the centre of various dressings under different conditions as to time, pressure and packing. These had convinced him that air was often not completely expelled from the sterilisers, there being sometimes a very considerable difference of temperature between the top and bottom dressings after five or six minutes. This was due to the pressure of air, which, being heavier than steam, collected at the foot, and was a bad conductor of heat. Vendors of sterilisers were too apt to omit to supply information on the extreme importance of allowing air to escape at the beginning of sterilisation. In the old Schimmelbusch steriliser, now frequently discarded in favour of its high pressure derivative, this could not happen, and it also had the advantage of providing a continuous current of steam during the whole process. The effect of packing the drums too tightly was very marked; a difference of 20°C. might be obtained by crowding a drum with too much dressing. Turning to drums, the defects of Schimmelbusch's pattern were pointed out. The hinges, shutters and bolts were all drawbacks; the lid soon ceased to fit closely, and the shutter mechanism was imperfect. A drum was then exhibited which the speaker had devised. It had a sliding-on lid, with a deep flange, round the lower part of which a series of large holes was pierced. The dressings were contained in a gauze basket inserted into the drum, the lid was put on, but not thrust home, so that steam entered the drum through the holes in the lid; when sterilisation was over the lid was pushed firmly down, so that this communication was blocked. The bottom of the drum had a small hole, occluded by a screw cap, by which water could be drained off if need be. In using the drum, Mr. Skirving had found that the dressing was much more effectually sterilised when the drum was put into the steriliser upside down, the explanation being that convection of heat then came into play, the hot steam ascending from the entrance holes in the lid, now lowermost, and reaching the top of the dressing much more quickly than it would descend to the bottom when the drum was placed upright, with the holes in the lid at the top. The great point about the drum was that it would preserve dressings sterile for a considerable period, which was not the case with ordinary patterns, as, owing to their complicated construction, they were never hermetically sealed, as Mr. Skirving's pattern practically was. The question of heating by convection was of some importance. In all drums heating of the contents resulted from (1) diffusion of hot steam; (2) conduction of heat. If the steam enters by the bottom, convection is added. Convection, as physicists knew, was the important factor

in heating a given quantity of water to a definite maximum temperature, and this idea might be considered in the vexed question as to whether steam is best admitted to sterilisers from below or from above. His final advice was, purchasers of sterilisers ought to get instructions from the makers, not from intermediate sources. In hospitals the ideal plan was to have a central steriliser managed by a thoroughly competent person. All small sterilisers should have pressure and temperature gauges, which should be tested from time to time. Occasional bacteriological tests should also be made, and the condition of the drums should be supervised.

## THE SPA TREATMENT OF ARTHRITIS DEFORMANS.

By W. BOWEN-DAVIES, L.R.C.P., M.R.C.S.,  
Llandrindod Wells.

I HAVE chosen the term "arthritis deformans" after the German and American schools, as I think it a better name for the disease than the more often used "rheumatoid arthritis" or "rheumatic gout," for in the majority of cases there seems to be very little rheumatism and less gout to do with this condition.

The disease is a different one, and requires a totally different treatment, and it is important that it should be dissociated from rheumatism and gout, for the treatment is quite dissimilar. There are, however, very few patients suffering from "arthritis deformans" who have not at one time or another taken drugs and adopted the diet that would be suitable in rheumatism or gout, such as colchicum or the salicylates, or used a low diet free from meat and alcohol. Now, all this treatment is decidedly detrimental to any patient suffering from arthritis deformans, and cannot be otherwise than harmful.

I happen to have had exceptional opportunities of studying this disease during the last few years, both in hospital and out; this must be my apology for bringing forward a type of disease so common to all of those who practise at spas, for though it does not directly lead to death, it certainly does to the most abject misery and progressive deformity.

I have never quite satisfied myself why this disease is practically confined to the female sex, but there is no doubt that it is common about the menopause, and that it is influenced greatly by uterine and ovarian disturbance. Again, mental shock is a very common cause of the onset of the disease, and any acute disease, not necessarily rheumatic fever, is sometimes followed by it.

Influenza seems specially to cause it. I remember one of the first cases that impressed itself upon my memory; it was a very instructive one. A woman, aged about 30, who had no gouty or rheumatic history, the wife of a farmer in seemingly prosperous circumstances. She had two children when I saw her first, and arthritis deformans had already a good hold of her. Her lassitude was extremely marked, and she had evidently made up her mind for a "sofa" life. Shortly afterwards her husband was suddenly killed, and it was found that his affairs were in a most unsatisfactory state; she was left with her two children without a penny. Her husband's

friends came forward and offered to adopt the two children. This she would not consent to; she said she would not part with them, but would make a home for them in a neighbouring village. This she did, and to gain a livelihood for herself and them she took in washing; most of her time was spent at the wash-tub.

I lost sight of her for three years, when she called on me. I hardly knew her, she looked so well, and the joints had almost recovered their suppleness, the lassitude had disappeared, in fact, the disease was cured.

Now what had caused this wonderful transformation? Undoubtedly the change in her life, the excessive exercise she took daily, the scrubbing and rubbing. She said she felt the pain very much at first, but after a time there was only extreme weakness, which lasted longer, but eventually passed away.

Many lessons are, I think, to be learned from this case, the benefit quickly obtained from the regular exercise and what was, to her, hard work. She told me she took little medicine, except cod-liver oil, of which she partook largely.

*Diet.*—It seems to me important that food should be taken not oftener than three times a day. What may be called "nips" of food or drink are bad, and three times a day is often enough to call upon the deranged digestive organs to act. A little alcohol does good, and may be taken in the form of sound malt liquor, stout preferable, or a light wine, such as Moselle, or a weak old whisky and water, but never between meals. Fats should be partaken of freely, especially milk in any shape or form. Extract of malt is a useful addition to the cod-liver oil. Lightly-cooked eggs are always useful. Fresh butter should be taken freely, at least a quarter of a pound daily. The diet should certainly be generous and nourishing.

As I have said before, plenty of exercise in the open air is absolutely necessary, and the more bracing the atmosphere the better. Every joint should be fully bent and extended each day, the patient should be advised to take long steps in walking, and not to sit on low chairs. Indeed, in one case, I recollect a patient who disregarded this advice, and usually sat on an extremely low drawing-room seat, which allowed the hips and knees to contract, until she could only walk in a sitting posture ever afterwards.

At Llandrindod Wells most cases naturally come under the mineral water treatment, and derive much benefit from the waters and baths. They usually take the waters in this form: The hot saline from three to six tumblers before breakfast, with a fifteen minutes' walk after each, and either the sulphur in five or ten ounce doses, with a twenty minutes' walk after each, between eleven and twelve o'clock, and sometimes between three and six o'clock as well, or the chalybeate three or four wineglassfuls two or three times a day after meals; of course this entails exercise.

The baths are found to be most useful, but never the reclining bath, always in the form of needle spray sulphur baths, or what we have found most useful in this complaint, some form of hot air bath, very hot. It is common advice to avoid cold and damp, and in all these cases, no doubt, this is very good advice, but patients often make this an excuse for not venturing out of the house at all, excepting in the finest weather.

Something has been said about the contagiousness of arthritis deformans. All I can say is, that in my experience of thirty-four years, and nearly a thousand cases of this disease, I have only twice seen two members of the same family affected with it, and could not make out any family history of the disease. I have never come across any cases that would give me any reason to consider that the disease in any way has been spread by contagion, nor, in my opinion, is it hereditary. One curious point has been observed, namely, that during the active progress of the disease the evening temperature continues about 99° or 100°, and never much higher.

The pulse, too, is usually found to be about 100; this continues for years, and is itself a valuable diagnostic sign. The extreme lassitude and want of energy which are so marked in these cases is also a valuable sign which seems always to be benefited by prolonged and active exercise in the bracing air. The cure seems a painful one, but is attended by wonderful results, if used diligently before the disease becomes incurable.

There is no doubt that few diseases are more curable, if this is persevered with when the disease is in an early stage.

### Clinical Records.

#### A CASE OF TRICUSPID INCOMPETENCY.

By S. J. Ross, M.D.

THE patient is a man, *æt.* 53, who for the past nine years has had a winter cough. There is no history of rheumatism or any other illness.

Four years ago he noticed that his cough was more troublesome, and his ankles began to swell towards the evening. He had marked dyspnoea. Two years ago when I first saw him his condition was as follows:—Marked cyanosis of lips and cheeks, chest barrel-shaped, lungs markedly emphysematous and *râles* to be heard all over the chest. Cardiac dulness masked by emphysematous lung. Epigastric pulsation very marked. No murmur to be heard; heart's action very irregular. *Pulse.*—100, very small, very irregular. Liver dulness depressed and increased, spleen enlarged. Urine, *sp. gr.* 1030, acid, albuminous; ankles very oedematous.

Steadily his condition became worse, and signs of cardiac dilatation became more marked. A limited soft systolic murmur is to be heard in the tricuspid area.

Hepatic pulsation very marked. Venous pulsation in the veins of the neck, the expansion being synchronous with systole, collapse with diastole. During attacks of coughing the veins attain an enormous size. All his organs were congested. *Lungs.*—Cough very troublesome, with slight hæmoptysis. *Liver.*—Pulsating, slight jaundice; hæmorrhoids. *Kidneys.*—Urine greatly diminished in quantity, of high specific gravity, and almost solid with albumen; spleen enlarged. *Stomach.*—Vomiting frequent, and occasional traces of blood in the vomited matter. Extremities of anterior abdominal wall oedematous. Ascites very marked. *Brain.*—Irritable, and insomnia a troublesome symptom.

*Treatment.*—With rest in bed and an exclusively milk diet, together with the administration of digitalis, the condition of the patient

rapidly improved. When digitalis was rejected strophanthus was retained, which acted equally efficiently, but more slowly. The improvement was so marked that the patient insisted upon getting up after ten days' treatment, and having a less restricted diet, which, of course, invariably ends in a relapse. During one of these relapses digitalis failed to act, the urine steadily decreased in quantity. Caffeine citrate with sodium benzoate was tried, and acted rapidly and efficiently, the urine, which had dropped to twelve ounces in twenty-four hours, after forty-eight hours' treatment rose to forty-eight ounces. For the insomnia trional and paraldehyde were successfully employed; the former drug requires watching, as cases are recorded in which its employment has induced acute nephritis. Ten grains at bed-time appears an efficient dose. Hypodermic injections of strychnine were from time to time necessary.

There was no change in the condition of the patient until three hours before death, which took place on June 28th. Then cerebral Cheyne-Stokes respiration appeared, in which there was sudden arrest and sudden return of respiratory movement. Cyanosis became very marked. The patient lapsed into coma and died.

*Remarks.*—The cause of the patient's heart condition was doubtless primarily pulmonary emphysema, so that the tricuspid incompetency was caused by a dilatation of the tricuspid orifice associated with failing compensation, rather than a true valvulitis. At no period of the illness was there any fever. The strictly limited area over which the murmur could be heard is worthy of note. The marked benefit resulting from rest and the administration of digitalis was very striking in this case.

## British Health Resorts.

### XVI.—BATH.

It is claimed that the virtues of the thermal springs, on which in great measure depends the reputation of Bath, were known in pre-Roman days. It is certain that during the Roman occupation of Britain Bath gained great distinction as a health station. During the eighteenth century it became a resort for the fashionable faddist; but of late years the place has been developed on sound rational lines, and the baths and waters can now be employed with something like scientific precision. (a)

Bath now occupies a foremost place among British spas. (b)

The hot springs which give Bath its unique value appear to have their source beneath the new red sandstone and lias in the palæozoic rocks. Meteorological observations have been regularly made at the stations equipped by the Corporation, and also at the Bath Royal Literary and Scientific Institution. (c)

The mean temperature for last year was 50.2°; the mean daily range, 13.3°; the humidity, 78; the total rainfall, 42.57 inches; and the total duration of bright sunshine, 1,378 hours. The thermal waters are derived from three springs—the Hot Bath of 120° F.; the King's Bath of 114° F.; and the Cross Bath of 104° F. In chemical constitution they are all similar. Calcium sulphate forms the most plentiful ingredient, varying from 80 to 100 grains per gallon. The total mineral matters are from 140 to 165 grains per gallon.

Local enterprise has now provided perfect arrange-

ments for the comfort and convenience of visitors. The Grand Pump Room, Roman promenade, and various baths are in every way excellent. All forms of hydro-pathic treatment are provided, and skilled attendants are always at hand to see that medical orders are fully and scientifically carried out.

The Bath waters can be used externally, taken internally, or, as is generally the case, employed in both forms. Therapeutically, Bath is of greatest service in cases of gout and gouty derangements of all kinds, rheumatism in its chronic forms, and in the remnants of disorder left by an acute attack, osteo-arthritis in some of its less progressive varieties; in muscular and arthritic derangements, such as lumbago, gonorrhœal and some other forms of arthritis; in sciatica and some cases of neuralgia, and chronic neuritis; in certain cutaneous affections, such as eczema, acne, psoriasis, senile prurigo, and particularly akin lesions due to constitutional disorder. In some cases of nervous deterioration, derangement of digestion, gouty respiratory affections, and some diseases peculiar to women, a course at Bath will often accomplish much.

Bath should not be advocated for patients with any form of acute disorder. Tuberculous cases usually do ill. It is not a good resort for "surgical" cases. Epileptics are said to gain no benefit. Marked cardiac disease and aneurysm or other vascular affections are to be regarded as contra-indications. Bath offers many attractions to the aged and the invalid who desires a quiet yet not altogether retired life, where while in the world he may not necessarily be of the world. The city is, moreover, well provided with hotels of all kinds, and excellent apartments can always be obtained. Bath is 107 miles from London, and can be readily reached by the Great Western Railway in a little over two hours.

## Transactions of Societies.

CLINICAL SOCIETY OF LONDON.  
MEETING HELD NOVEMBER 11TH, 1904.

The President, DR. TAYLOR, in the Chair.

MR. C. R. KEYSER narrated the case of a girl, æt. 9, who was admitted into hospital in December, 1903, with a Congenital Elevation of the Scapula. The deformity had been noticed for one month only. There was no history of injury, and no similar case was known in the family. The left shoulder was 2½ inches higher than the right; there was no osseous ridge connecting it to the spine. The third dorsal vertebra was prominent and displaced slightly to the left. There was no paralysis of the arm or of any local muscle. Evidences of slight rickets were present. Cases of this class were rare, and fell into four groups: (1) Those having an osseous ridge joining the scapula to the spine; (2) those with absence of one or more muscles of the shoulder or girdle; (3) those with a long, everted, supra-spinous portion of the scapula; (4) those in which the scapula was small, but in which no other abnormality of bone or muscle was present. This group comprised most of the cases. The affection was usually unilateral, and occurred more frequently on the left side. Other deformities, such as spina rigida, were often present. Sprengel's theory as to the pathology of the condition was that the arm was misplaced behind the back *in utero*. The formation of the bony ridge, which was present in some of the cases, was discussed, and references made to other recorded examples of the deformity.

MR. RUPERT BUCKNALL had seen an exactly similar case, and several cases closely resembling the one described. The bulk of evidence was against the condition being an acquired one or, as Sprengel thought, due to malposition *in utero*. If the latter theory were true, one would expect to get deformity of the arm and hand. The question of the osseous ridge was a very interesting one. He thought that it was probably not of supra-scapular origin, for if the muscles were carefully examined, whether they were shortened, fibroid,

(a) See article by the late Dr. W. M. Ord and Dr A. E. Garrod, in "Climates and Baths of Great Britain." Vol. I. 1895.

(b) See "Medical Guide to the Hot Mineral Baths of Bath." 1901.

(c) "Thirty-eighth Annual Report of the Medical Officer of Health," by Dr. W. H. Symons. 1904.

or bony, their condition always accurately accounted for the position of the scapula, that being sometimes elevation, sometimes rotation, and sometimes adduction. If the rhomboids were affected, adduction occurred; if the trapezium, elevation. Often the osseous ridge did not accurately correspond with the muscle, *i.e.*, it was not confined to one given muscle. This fact had been read as indicating that the change occurred in very early life, before differentiation of the muscles had taken place. This theory also was in line with the presence, in these cases, of deformities in the spine and elsewhere.

Mr. KEYSER said that the presence of cartilage between the scapula and spine did not fit in with the primary muscular defect theory.

Dr. PHILIP TURNER and Mr. RAYMOND JOHNSON described a case of Traumatic Axillary Aneurysm, in which, after extensive extravasation had occurred, a successful result was obtained by the application of a ligature to the axillary artery in the first part of its course. The patient, a woman, *æt.* 70, fell downstairs on to the left shoulder, the injury being followed by much bruising of the part and paralysis of the hand and forearm. Three weeks later, it was found that a pulsating tumour as large as a tangerine orange was present in the anterior part of the axilla; the pulse at the wrist was not perceptible. After the lapse of several months great improvement had occurred in the muscular power, and the radial pulse was again perceptible. During the third year after the accident, some gradual increase was noticeable in the size of the aneurysm, without, however, any symptoms of pressure. Nearly three years after the onset, a small bruise appeared over the posterior axillary fold; and a few days later a considerable extravasation occurred, with intense pain and extensive discoloration of the skin. The axillary artery was tied in the first part of its course. On the morning of the operation, it was found that blood was just beginning to leak through a small opening which had formed spontaneously in the discoloured skin. All pulsation in the axilla was arrested by the ligature, but no anxiety was at any time felt as to the vitality of the limb, the circulation in which remained good. The opening in the skin of the axilla continued to discharge slightly until about three weeks after the operation, when a very free escape of the extravasated blood occurred, and after slightly enlarging the opening a quantity of coagulum was removed. From this time the discharge quickly lessened, the swelling gradually and completely subsided, and the final result was in every respect satisfactory. It was pointed out that the chief practical interest of the case consisted in the fact that a traumatic axillary aneurysm, after the occurrence of extensive extravasation, was successfully dealt with by the proximal ligature. According to the usual teaching on this subject such a favourable result was hardly to be expected in such circumstances and at such an age. Probably the long duration of the aneurysm had a favourable effect, by causing the collateral supply to be well established. The treatment adopted was far less severe than the alternative method of freely opening up the axilla and dealing with the artery at the site of the aneurysm. Reference was made to certain cases recorded by Major Birt, of traumatic aneurysm from bullet-wounds, in which the treatment by proximal ligature was adopted with success. In two cases of diffused extravasation into the axilla a successful result followed ligature of the subclavian artery in the third part of its course.

Mr. H. BETHAM ROBINSON and Mr. EDRED CORNER narrated a case of Aneurysm of the Intracranial Part of the Left Internal Carotid Artery, caused by a bullet wound through the right eye entering about the right outer canthus and completely destroying the globe. There was no wound of exit. When admitted into St. Thomas's Hospital immediately after the accident, the patient was unconscious and showed signs of cerebral irritation. The right eye was at once excised. On the seventh day the left eye was suffused and the cornea dull; on the eleventh day there was severe

epistaxis, controlled by plugging the nares; and on the thirteenth another, more severe. The cornea ulcerated, and on the twenty-fourth day sensation was absent over nearly all the distribution of the upper two divisions of the fifth nerve; ptosis and paralysis of the sixth nerve occurred; complete ophthalmoplegia externa occurred on the thirty-third day. After several attacks of hæmorrhage, which always came from the right nostril, the same side as the destroyed eye, Mr. Corner ligatured the internal and external carotids on the right side. On the sixth day after this she woke up completely blind, this being thought to be due to some lesion of the optic nerve behind the entrance of the central vessels. There was a transient hemiplegia on the left side. From now onwards there was no further hæmorrhage, and her general condition gradually improved, the partial paralysis passed off, and consciousness returned. On the 195th day she was sent to a convalescent home, being quite well, no bleeding having occurred since the 118th day. This period of improvement lasted for another twenty days. She was then readmitted for another severe hæmorrhage from the right nostril, which was stopped by plugging. Three days later a very violent hæmorrhage occurred, and she died in three minutes. At the autopsy the bullet was found to have pierced the inner wall of the right orbit, traversed the body of the sphenoid, and entered the interior of the skull close to the left anterior clinoid process. From this point it had turned backwards and lodged on the under surface of the brain close to the calcarine fissure. A splinter of bullet had branched to the left and lodged in the under surface of the hinder part of the temporo-sphenoidal lobe. Close to the anterior clinoid process was a small aneurysm of the left internal carotid artery, and lodged in its wall was a splinter of bone. The sac communicated with the track of the bullet, and so with the right side of the nose, along which the fatal bleeding had taken place.

Mr. STEPHEN PAGET described the case of a girl, *æt.* 13, whom he operated on for Acute Appendicular Abscess. Five ounces of thick, foetid pus were evacuated. Nine days afterwards another abscess appeared in the left iliac region between the bladder and rectum, and a pint of pus was again evacuated. The patient, after recovery, complained on several occasions of colicky pain in the abdomen. Fifteen months later, she was seized with severe pain and vomiting. The abdomen was opened and a coil of gut was found to be nipped by an adhesion which extended transversely across the abdomen. From this operation the child made a perfect recovery. Stress was laid on the following points:—The appendix was removed at the first operation, so that the extension of suppuration to the left iliac region was not due to a septic appendix having been left in the wound. The intermittent pains that followed the earlier operations were accompanied by nocturnal epilepsy, which perhaps caused the gut to get caught by the adhesion. These pains were vaguely attributed to stretched adhesions, and their true significance not realised. After double suppuration in the abdomen, acute intestinal obstruction was likely to be caused by an adhesion between the two foci and not at either. No epileptic fits occurred while the wounds were open, but began as soon as these healed.

Dr. FRENCH asked whether it was the rule for the fits to cease in epilepsy while operation wounds were present. Perhaps anti-epileptic treatment was being carried out more vigorously at this time.

Dr. PASTEUR inquired as to the frequency of adhesions after abdominal operations.

Mr. MCGAVIN said that the question of post-operative adhesions was a very important one. They might be expected to occur after an acute inflammatory condition such as that present in Mr. Paget's case. He referred to a case in which laparotomy was done for tuberculous peritonitis and no adhesions found. Later, acute intestinal obstruction occurred, and the child died, the parents refusing operation.

Mr. R. P. ROWLANDS described a similar occurrence many years after an ovariectomy.



Mr. ZUM-BUSCH had operated on many cases of ventral hernia consequent on appendix operations.

Mr. PAGET stated that no bromide had been administered to the child during her stay in hospital, as the epilepsy was only discovered shortly before her discharge. He remarked on the great variations in the number of adhesions that occurred in different patients, instancing the occasional cases of extreme and fatal prolapse through colotomy wounds as evidence that sometimes no adhesions at all were present.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.  
MEETING HELD NOVEMBER 2ND, 1904.

PROFESSOR JOHN CHIENE, President, in the Chair.

MR. C. W. CATHCART showed (1) a patient after operation for fæcal fistula; and (2) a case of scirrhus erythema after removal of both mammae for scirrhus.

MR. ALEXIS THOMSON showed (1) a boy, æt. 15, after nephropexy for floating right kidney. The youth of the patient was commented on as unusual. (2) A woman, æt. 27, after conservative operation for hydro-nephrosis. The kidney was displaced down, and the ureter, though not kinked, did not, on account of the level at which it entered the kidney, drain the pelvis of the organ properly. There was a large sacculcation below the exit of the ureter. The treatment consisted in raising the kidney, and fixing it in its normal position, so that the ureter drained the most dependent part of the pelvis. (3) A case of popliteal aneurysm treated by excision of the sac after distal ligation; though it relieved the symptoms, this had failed to cure by causing coagulation in the sac.

DR. G. A. GIBSON showed a specimen of sarcoma of the root of the left lung involving the pericardium.

MR. SCOT SKIRVING showed a drum for sterilising and storing dressings.

MR. SCOT SKIRVING read a paper, entitled

QUESTIONS REGARDING THE STERILISING OF  
DRESSINGS,

a full abstract of which will be found on page 512.

The paper was discussed by Messrs. Macgillivray, Cathcart, Caird, and Dr. Littlejohn.

DR. MELVILLE DUNLOP read a paper on

SYPHILITIC SYNOVITIS IN CHILDREN.

The condition was one deserving of wider recognition than it had generally received, and was much more frequent than was usually supposed. After a brief reference to the literature of the subject, the speaker said that syphilitic arthritis was very often confused with other forms of chronic joint disease, but that it was of great importance to recognise its true character, as otherwise it was very likely to be treated, unsuccessfully, as if it were tuberculous. It might occur either in acquired or hereditary syphilis, but was much more common in the latter. Sometimes an acute synovitis was met with before the eruption appeared; gummata of the joints had been described, chiefly as secondary to gummata in the adjacent bone, this form being liable to confusion with sarcoma. All these, however, were rare in childhood. The common forms of syphilitic synovitis in children were two in number—(1) synovitis secondary to syphilitic epiphysitis in infants, due to extension of the mischief from the epiphysial line. In these cases there was first the epiphysitis running on, sometimes, to separation of the end of the bone, with degenerative changes in the articular cartilages. If suppuration occurred it was due to a secondary infection, not to syphilis alone; the pus might invade the articulation, causing an abscess in the joint. The condition usually developed rapidly during the first three months of life. It affected the arms, and particularly the distal joints, in preference to the legs, was usually symmetrical, one side, however, being worse than the other. On examination, swelling could be felt in the neighbourhood of the epiphysis, the joint contained a little fluid, tenderness might be present or absent, and powerlessness of the limb—syphilitic pseudo-paralysis—was an almost constant

accompaniment. When separation of the epiphysis occurred, there was unnatural mobility; crepitus, however, was rare. The prognosis was good as to restitution of the function of the limb; shortening did not tend to occur, and suppuration was rare. Two illustrative cases were briefly recorded. (2) True primary chronic syphilitic synovitis.—This was a late tertiary manifestation, it was very insidious, and was often discovered accidentally. The disease usually occurred in children, æt. between 8 and 15, at the age at which interstitial keratitis was frequent. The arthritis was very symmetrical, and of all joints the knees were most likely to be involved, the ankles and elbows much less commonly, while no instance of affection of the shoulders or hips had been recorded. The disease did not attack the two joints simultaneously, but at an interval varying from two or three weeks to several years. In this respect, in its favourable course, and in its date of onset, it presented certain resemblances to interstitial keratitis, with which, as a matter of fact, it was not uncommonly associated, and it was to the ophthalmologists that some credit was due in the recognition and recording of the affection. Generally speaking, one joint was more severely affected than its neighbour. The onset was very gradual and quite painless, and, except for some stiffness, the function of the limb was not interfered with. In consequence of the latency of the symptoms, the condition was, therefore, very liable to escape the notice of unobservant patients. On examining the joint a swelling was found, due entirely to synovial effusion, with sometimes slight thickening of the synovial membrane. There was no redness, no starting pains at night, no creaking, and no pain or tenderness; only slight loss of mobility. It had been stated that as many as 75 per cent. of cases of keratitis showed some degree of this joint lesion. The other stigmata of syphilis—Hutchinson's teeth and deafness—might be present; nodes were particularly frequent. The condition was by no means uncommon; Dr. Dunlop had met with some sixteen cases. Relapses were very liable to take place. Little was known as to the pathological changes, as the cases were seldom fatal. On the whole they seemed to be slight—a little hyperæmia of the synovial membrane, some thickening of the fingers in some cases, sometimes villous outgrowths developed in the synovial pouches, in one or two instances small gummata had been present. The diagnosis rested on the bilateral symmetry of the arthritis, the insidious onset, absence of pain, and slight loss of function. As to the treatment, although not all cases responded to anti-syphilitic remedies, the disease was usually very amenable to mercury and potassium iodide. Several cases illustrating the various points raised were reported.

DR. CHALMERS WATSON gave a communication, of which the following is a very brief *résumé*, illustrated by a lantern demonstration, on

GOUT: OUR PRESENT POSITION WITH REGARD TO ITS  
ETIOLOGY.

All our views of gout, he remarked, were coloured by the influence of Garrod's teaching that uric acid is the primary factor in the disease, and this theory has been almost universally accepted, e.g., by Ebstein, von Noorden, Roberts, and others. Of late years, however, this view has been questioned by clinicians, among whom Goodhart's name might be mentioned. The author's investigations had led him to abandon the view that uric acid was an important etiological factor, the steps leading to this being, shortly, as follows:—

A. *Chemical*.—Uric acid was found in the blood in a number of diseases having no known relationship to gout, thus confirming the work of previous observers. In leucocythæmia, for instance, uric acid was present in quantities far exceeding that found in gout, and it was impossible to imagine that if the uric acid acted as a poison its action should not be greater, the more there was of it in the tissues. Further, an analysis of the urine in acute gout showed no disturbance of the

uric acid secretion, either before, during, or after the paroxysm; and the same results were got in the administration of nucleins to gouty persons.

**B. Histological.**—The morbid appearances observed in gout in the lower animals and chronic gout in man do not support the uric acid theory, but rather suggest an infective condition. After removing urates from a gouty joint remarkable hyaline structures are seen in the position occupied by the crystals. There seemed no more reason for ascribing gout to the presence of the crystals than to the presence of these hyaline structures. In these, by special stains, Dr. Watson had demonstrated masses of rods, apparently micro-organisms. He was of opinion that the uratic crystals gave the general inflammatory condition of the gouty tissues its specific character, but were not otherwise essential features of it.

**C. Clinical.**—The features of an acute attack—the manner of onset, temperature curve, and blood changes indicative of a disturbance of the marrow function—all suggested the operations of an infective agent. The general conclusions arrived at were that uric acid is not an important etiological factor in the production of gout. This should be considered in relation to the recent views of Woods Hutchinson, Poynton, and Gore. There is an infective element in the disease, and the uric acid gives to the inflammation its specific character. According to this view the source of infection is the alimentary tract, and an injudicious dietary—meat or drink—acts mainly in virtue of its influence on the bacteria normally present in the digestive tract. Reference was also made to the likely times for fruitful investigations, an inquiry into the state of the blood and marrow being suggested as not unlikely to throw fresh light on the disease.

Dr. GULLAND was not inclined to accept Dr. Watson's thesis as proved, and did not consider that he had by any means overthrown the uric acid theory.

Dr. TAYLOR thought that influence of the nervous system in producing gout must be taken into account.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF SURGERY.

MEETING HELD FRIDAY, NOVEMBER 4TH, 1904.  
The President, Mr. ARTHUR CHANCE, in the Chair.

#### EXHIBITS.

Mr. KENNEDY exhibited a patient after nephrectomy, and the diseased kidney which had been removed; also cases of excision of the knee- and elbow-joints.

Mr. EDWARD H. TAYLOR exhibited a man, *æt.* 39, whose left lower extremity he had amputated through the hip-joint for an osteo-sarcoma of the femur; (2) specimens of rectal cancer removed by the trans-sacral and by the combined sacro-abdominal method; also (3) some unusual forms of urinary (bladder) calculi.

Mr. R. J. MONTGOMERY exhibited a patient showing the result of operation for ectropion of both lower eyelids.

Sir THOMAS MYLES exhibited (1) some recent cases of gastro-jejunostomy; (2) carcinomatous and tuberculous kidneys removed by nephrectomy; and (3) a large fibroma removed from the region of the lesser peritoneal sac.

Mr. W. S. HAUGHTON exhibited (1) case of omento-hepatopexy; (2) case of excision of astragalus for dislocation of thirteen months' standing; (3) case showing new method of "screwing" fractured olecranon.

Mr. MAUNSELL exhibited (1) examples of different forms of goitre; and (2) some pathological vermiform appendices.

Mr. J. B. STORY exhibited an improved mask to exclude buccal microbes from operation wounds.

Mr. SETON PRINGLE exhibited an ano-coccygeal tumour.

Mr. A. B. MITCHELL (Belfast) exhibited a specimen showing the condition of parts after gastro-jejunostomy, followed subsequently by jejunostomy for the relief of regurgitant vomiting.

Mr. A. B. MITCHELL (Belfast) read a paper entitled

"Inefficient Operations for Gastric Ulcer." The paper was based on the results of four different operations, which gave relief for a time, but in all of which the symptoms subsequently recurred.

*Case I.*—A small ulcer on the anterior wall of the stomach was freely excised. Recovery was rapid, and for about a year the patient remained in excellent health; then the old pain recurred, and though some relief was obtained from drugs and diet, her condition was far from satisfactory.

*Case II.*—A large ulcer, which had existed for about twelve years, was infolded by a row of continuous sutures which extended four-fifths round the stomach. The immediate result was all that could be desired, but about eighteen months after operation the symptoms returned, and the patient was soon as bad as ever. A posterior gastro-jejunostomy gave complete and probably permanent relief. The relapse was due to the development of another ulcer higher up in the stomach, all trace of the former ulcer having disappeared.

*Case III.*—A case of well-marked hour-glass stomach had been treated by gastro-gastrostomy. The patient, who had been a chronic invalid for over twenty years, was promptly restored to health and she remained well for one year, then relapsed. Perforation occurred, and she was operated upon and recovered, and finally a gastro-jejunostomy was done in order to afford permanent relief.

*Case IV.*—A gastro-duodenostomy was done for relief of long-standing stomach trouble. The immediate result was most satisfactory, but as the symptoms relapsed in about eighteen months, a posterior gastro-jejunostomy was performed with good result.

These cases were placed on record because a true account of unsuccessful operations is essential to a scientific estimate of the best line of surgical treatment. Mr. MITCHELL expressed the opinion that permanent relief could not be secured except by an operation that did away with the action of the pyloric sphincter, and secured prolonged drainage of the stomach. He now always performed posterior gastro-jejunostomy. He related two cases of regurgitant vomiting. In the first an anastomosis between the ascending and descending loops of jejunum was made, but the result was very disappointing. The patient recovered well from the operation, but got no relief from the vomiting, and died of exhaustion. (Specimen shown.) In the second the bowel was divided, and a Y-operation performed. The result was entirely satisfactory.

Sir THOMAS MYLES stated that his experience of gastro-jejunostomy for gastric ulcer was small, but he had performed the operation for other conditions, such as pyloric obstruction and malignant disease. He thought it would be a matter of considerable interest in cases where gastro-jejunostomy had been performed for the relief of gastric ulceration with hyperchlorhydria to ascertain the condition of digestion afterwards. For regurgitant vomiting he found relief was usually afforded by propping the patient up in bed. He had never found it necessary to perform a second operation after gastro-jejunostomy, and had operated in sixty-one cases without a death. In order to prevent a spur forming at the site of the gastro-intestinal junction he usually sutured the jejunum along nearly the entire length of the posterior wall of the stomach.

Mr. MITCHELL, in reply, stated that experience had led him to prefer gastro-jejunostomy to other operations in cases of gastric ulcer. With regard to regurgitant vomiting, he had observed that when gastro-jejunostomy was done for pyloric obstruction there was never any trouble in this respect, and latterly, when performing gastro-jejunostomy, he had been in the habit of puckering in the pylorus with three or four sutures, thus doing away with the action of the pyloric sphincter, and these cases were amongst the most satisfactory which he had had.

Mr. W. S. HAUGHTON read a paper entitled:—  
THE HEALING OF WOUNDS: ASEPTIC *v.* ANTI-SEPTIC METHODS.

Mr. Haughton, after paying a tribute to the greatness

of Lister's discovery, said that aseptic *technique* was the natural outcome of the principles of Listerism. There was no antagonism between antiseptic and aseptic methods, when properly used—*i.e.*, to reinforce each other when special circumstances required. But there was considerable antagonism between the so-called schools arising from the different value each school attributed to the power of chemical germicides and ordinary cleanliness. His opinion of the leading features of the aseptic surgeon were his appreciation of real cleanliness, his capacity for cleansing and sterilising his operation environment; his ability to maintain the aseptic chain unbroken in a long operation; and his "abstinence" (to use Kocher's own word) from touching sepsis between operations by using rubber gloves for all septic dressings, &c. He then gave Professor Kocher's classification of the channels of wound infection—*vis.*, through air, contact, inoculation, implantation, wound necrosis, and incubation, describing how each might be prevented, and the full details of this *technique* by which they were prevented. Speaking of skin disinfection, Mr. Haughton gave the results of his own experiments from time to time, the latest being done for him by Dr. Earl, which corroborated those of Kocher, Ahlfeld, Needham Green and others—setting great value on the hot-water-dilute-alcohol method (75-80 per cent.), which was equal, if not superior to, hot-water-sublimate methods, and probably also gave a longer period of safety by hardening the skin. Mr. Haughton advocated rubber gloves in all operations—aseptic and septic—as ligatures were freely infected by drawing them tight across the skin of the operator's fingers, and emphasised their value between operations, in dressing or examining septic or mucous surfaces. He further stated that more purely aseptic *technique* in his own practice gave more ideal healing of wounds. While primary union and absence of fever were the rule in his antiseptic days, they were still the rule in his aseptic *technique*; but in addition there was an almost complete absence of pain, even in the most extensive procedures, more rapid healing, which was also firmer and developed less fibrous tissue. Furthermore, in accidental wounds, such as compound fractures and lacerated contused wounds, he attained a higher percentage of aseptic healing when these were only treated by scrupulous and prolonged cleansing, using normal warm saline solution instead of any antiseptic germicide. In conclusion, he said the less one relied on chemical germicides, and more on prolonged cleansing, sterilisation by boiling, and warm normal saline solution, the more satisfactory were the results both to patient and surgeon.

Mr. LENTAINÉ said that as to the definition of aseptic and antiseptic surgery, he understood aseptic surgery to mean where nothing went into the wound in the shape of an antiseptic, chemical or otherwise, and antiseptic surgery, where septic processes in wounds had to be fought by the aid of chemical antiseptics. He considered it a matter of impossibility in general surgical practice to avoid occasional contact with sepsis, and accordingly he did not consider one could rely solely on aseptic measures.

Mr. TOBIN thought the ideal condition of things would be that in which all surgeons used the same methods. It would be well, too, if surgical nurses were all trained on similar lines. He did not think the danger likely to follow from puncture of rubber gloves during an operation very great.

Professor BENNETT agreed with Mr. Haughton as to the advantage of using alcohol as a final disinfectant in cleansing one's hands and the surroundings of a wound. He had found, however, that alcohol applied to the skin of his arms produced severe urticaria; he had found no unpleasant consequences from employing it for his hands.

Colonel McNece, R.A.M.C., Sir Thomas Myles, Mr. Wheeler and Dr. Earl also discussed the paper.

In reply, Mr. HAUGHTON thought that abstinence from sepsis should be the constant aim of the aseptic surgeon, and the best way to do this was by wearing

rubber gloves when dealing with septic cases of all kinds. In the treatment of actually septic wounds he thought weak antiseptics were better than those of greater strength, as the latter acted injuriously upon the tissues. He considered alcohol at a strength of 70 per cent. was better than full strength when employed for the hands. He thought silk was an absolutely satisfactory ligature material for burying in wounds, if No. 1 were used. At the conclusion of his paper Mr. Haughton showed a series of lantern slides illustrating various points in aseptic *technique*.

LIVERPOOL MEDICAL INSTITUTION.  
MEETING HELD NOVEMBER 3RD, 1904.

DR. JAMES BARR, President, in the Chair.

DR. GROSSMAN demonstrated a case of "double congenital anophthalmos" in an otherwise well-developed child, eight months old. The lids were well-formed, though only half an inch in length, and the conjunctival sac was a narrow funnel barely half an inch deep. In the inner half of the right lower lid, a bluish subcutaneous cyst, about half an inch in diameter, was very conspicuous, a so-called coloboma cyst. No trace of a rudimentary eye-ball was to be felt, or seen. This was the third case of the same nature shown by Dr. Grossman before the Institution within the last four years.

AN IMPROVED INHALER FOR ETHYL CHLORIDE.

DR. STENHOUSE WILLIAMS exhibited an inhaler for the administration of ethyl chloride. The apparatus was so constructed that the bottle containing the ethyl chloride is held in position over a tube with a stop tap which passes directly into the bag of a Clover's inhaler. By this means as much ethyl chloride as is required is sprayed into the bag, and then the tap turned off; the administration may thus be continued indefinitely.

Mr. G. P. NEWBOLT showed a male patient, *æt.* 38, from whom he had removed a large colloid carcinoma of the cæcum, six months previously. The growth had caused no obstruction; it was removed through a transverse abdominal incision, the resulting scar being an excellent one. He also related a case of intestinal obstruction occurring in a female, *æt.* 53, for which he had performed left inguinal colotomy. There was a marked sigmoid curve, and the fæces passed through the lower opening of the colotomy wound. Three months later the carcinomatous growth causing the obstruction, and the artificial anus, were simultaneously excised. The patient made an excellent recovery.

MR. K. W. MONSARRAT read an account of a case of FRACTURE OF THE FEMUR IN A HÆMOPHILIAC.

The patient was a boy, *æt.* 8. At the seat of fracture there was an enormous local effusion which progressively increased up to the fourteenth day, and was accompanied by a steady rise of temperature. His personal history indicated hæmophilia, and he showed signs of the disease elsewhere during his stay in hospital. Union of the fracture took place early; by the end of the fourth week it was already firm. The local effusion simulated an inflammatory condition, and before the personal history was inquired into, it was looked upon as probably of this nature.

Mr. DOUGLAS CRAWFORD referred to a case of hæmophilia with effusion into the knee-joint, in which, on account of the pain and temperature, simulated acute arthritis. He opened the joint, and a satisfactory recovery followed.

Dr. HUGH R. JONES read a paper on the distribution of

PHTHISIS AND CANCER IN ENGLAND AND WALES. Having pointed out the difference in the age and sex incidence of the two diseases, he drew attention to certain similarities in their history and distribution. It was proved that cancerous persons had a family history of phthisis greater than obtains in the general population, and that a high percentage of phthisical persons had a cancerous family history. The two

diseases are more prevalent near the sea-line. Cancer areas either overlap, or are contiguous to, phthisical areas. In central England, both cancer and phthisis are below the average. The death-rate from phthisis reaches its zenith at the 35-45 age period, the period at which the cancer death-rate begins to increase. He pointed out the frequency with which arrested phthisis and obsolete tubercle were found in cancerous persons. He believed that the recorded increase in cancer was in part real, and not altogether explained by improved diagnosis, nor by the increased population living at higher age periods, owing to the fall in the general death-rate, which would not affect the cancer death-rate, but probably due to the fall in the phthisis death-rate, resulting in members of phthisical families surviving to the cancer age, such persons being more prone to cancer than the general population.

Dr. WILLIAM CARTER thought that on the question of cancer and phthisis one might well consider, side by side with statistics, certain great changes in the national habits. Ever since the Registrar-General's office had been founded, some seventy years ago, a steady advance in the mortality from cancer had been recorded. Within that period bleeding, which at first was universal, had been totally discarded; the use of mercurial compounds, the greatest of antiseptics, like bleeding once universal, had been largely abandoned. The consumption of meat per head of the population had probably increased many times over, and the people who had lived simple natural outdoor lives had become aggregated in dense masses in towns. It was quite open to consideration whether all these great facts might not be related to each other.

Dr. R. J. M. BUCHANAN recognised the importance of the peculiar fact that in many cases of cancer obsolete tubercle was found *post-mortem*, and also the close relationship in family history between tuberculosis and cancer; but he did not consider that the increased death-rate from cancer proved increase of incidence as real, or that it in any way depended upon the lowered death-rate from phthisis. The prophylaxis exercised against tuberculous infection by lowering both the incidence and death-rate from phthisis had resulted in more persons now living until they reached that period of life in which cancer is recognised as most likely to occur.

Mr. K. W. MONSARRAT said he did not consider that any particular relationship had been established as existing between cancer and phthisis.

Dr. J. HILL ABRAM thought the chart of Dr. Jones, illustrating the marked difference between the apparent and the corrected death-rate from cancer, was very important, and demonstrated the great care necessary in dealing with figures.

#### LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, NOVEMBER 4TH, 1904.

A MOST interesting specimen of

ACTINOMYCOSIS IN THE TONSIL of a female child, together with bacteriological sections, was shown by Mr. ARTHUR CHEATLE and Dr. EMMERY. It was agreed that this was probably the second case only which had ever been recorded of actinomycosis in that region.

Several specimens of malignant disease in the upper air passages of the dog and cat were shown by Professor HOBDAY and Mr. DE SANTI, and an interesting case of probably extrinsic malignant disease of the larynx in a man, *æt.* 64, by Dr. FURNISS POTTER.

The case was unusual in the fact that it had lasted some eighteen months without any glandular infection. It was looked upon as a particularly suitable case for laryngectomy.

An interesting specimen of a foreign body—a collar-stud—was brought forward by Dr. PATERSON, the foreign body having been removed by direct laryngoscopy, Killian's method, from a child, *æt.* 12 months.

Mr. WAGGETT brought forward a diagnostic speci-

men from an oesophageal stricture removed by Killian's method. He pointed out that oesophagoscopy in England seemed not to be as well known, as a method of diagnosing strictures of the oesophagus, as it should be.

Mr. DE SANTI showed a case of curious erythema of the soft palate and tonsillar region in a girl. The question was as to the nature of the trouble. One or two members looked upon the case, though unique, as probably of the nature of angioma.

Dr. KELSON showed a case of laryngeal growth in a boy, *æt.* 6, the interest of which was that the growth had been removed in the sitting-up posture by endo-laryngeal forceps and deep anaesthesia.

Mr. H. B. ROBINSON showed a case of pharyngeal obstruction from a diaphragm which stretched between the back of the tongue and the posterior wall of the pharynx.

Dr. LAW showed a case of stenosis of the trachea, ozænic in nature, and Dr. DUNDAS GRANT a microscopic slide of an extrinsic laryngeal growth, the diagnosis resting between sarcoma and fibroma.

#### CHILDHOOD SOCIETY.

MEETING HELD NOVEMBER 10TH, 1904.

SIR JAMES CRICHTON BROWNE in the Chair.

Dr. THEO. B. HYSLOP began by saying that alienists had before them a problem asserting itself with overwhelming force, the percentage of insanity having quadrupled itself in fifty years, these figures not including imbeciles, hysterics, drunkards, neurasthenics, or the feeble-minded, but simply those under control. With regard to physical training in youth, it had to be borne in mind that school games involved a wide range of mental activity, and the boy fresh in from a strenuous game was not fitted to use his brain to a similar effort. Athleticism and games must be complementary. A severe strain in either course when young was felt all through life.

All were agreed as to education, but to force any mental effort on stunted, underfed children was both inhuman and impolitic. Half the children in Board Schools were unfit for lessons, and it would be cheaper to feed them than to pay for them afterwards as pauper lunatics.

Acute mania had not increased so much as that weak-mindedness which might be regarded as a product of the last few decades.

The mental condition at the present day was one of psychorrhœa gravis. There was diffuse consciousness, ill assortment of ideas, and a lack of seriality of thought easily passing into a state of insanity.

That loss of memory so frequently noted in the papers really marked a form of epilepsy. There was a want of economy in brain power. It did not appear that education, so-called, had done much when efforts had to be made in the way of workhouses, almshouses and asylums to keep pace with increasing insanity.

In concluding, Dr. Hyslop spoke of our unphysiological daily habits. The turning night into day and having to sleep when the brain should be at its brightest. Theatres and concert halls should be closed at ten. In fact, we were two hours too late in everything, and the results, although apparent in us, were manifested chiefly in our progeny.

SIR JAMES CRICHTON BROWNE, in reply, said it was impossible to ignore the weakness of a social system which led to increase in wastrels, criminals, lunatics and juvenile delinquents, and the remedy lay, as Dr. Hyslop had pointed out, in proper care of the young when the association fibres of brain were forming irresistible habits of mind and body. Clever people had more of these fibres than others, but in all brains they were forming pathways made indelible by use. Our annual lunacy returns ought to silence the genial optimist who drags the public by pretending these are unreliable. Brudenell Carter says the attempt to explain away the larger number of lunatics is puerile. Physical deterioration must involve the

brain, and inquiry into its cause and cure was quite as momentous as that into cancer or tuberculosis.

He (Sir J. C. Browne) also agreed with Dr. Hyslop that from a purely scientific point of view some kind of religious instruction was necessary.

#### ASSOCIATION OF PORT SANITARY AUTHORITIES.

THE annual meeting of this association was held at the Westminster Palace Hotel. Alderman C. H. Giles, chairman of the Liverpool Port Sanitary Authority, was elected President, in succession to Dr. Fraser (Hull), and took the Chair. In thanking the members for the honour conferred upon him, he said the Association increased every year in importance, and it was doing good work for the community at large. Alderman Hindmarsh was elected Vice-president, and other officers were appointed. Mr. R. Sheriton Holmes, the hon. solicitor, read some notes on "The Association of Port Sanitary Authorities' Expenses Bill," which provides for the expenses of representatives attending meetings and the payment of a subscription to the funds of the Association. He suggested that the sixty port sanitary authorities in England should be asked to memorialise the Government in favour of taking up the Bill, and a resolution to that effect was adopted. In a paper on "The Recent Case of Plague in the River Tyne," Dr. W. E. Harker said it was probable that the patient developed the disease by direct inoculation from rat infection, although no definite point of entrance or insect bite could be demonstrated on the skin. The case afforded further proof of the great danger of plague-infected vermin on board ship. Dr. E. W. Hope (Liverpool) and other members said the case illustrated the importance of the systematic destruction of rats in all vessels coming from plague-infected ports. A discussion on "Amendments in the By-laws relating to Infectious Disease" was opened by Dr. Hope, who said the present penalty of 40s. for breaches of the regulations by masters of vessels was wholly inadequate. He suggested that it should be raised to £50 or £100. The question of the desirability of the taking of samples of food for analysis by port sanitary authorities under the Food and Drugs Acts was brought forward by Dr. J. Wright Mason (Hull), and after a brief discussion the matter was referred to the council. The meeting also referred to the council for consideration the subject-matter of a resolution by Dr. A. M. N. Pringle, the Medical Officer of Health of the Manchester port sanitary authority—which that gentleman afterwards withdrew—in favour of the control of the sanitary arrangements of mercantile vessels, both during and after construction, being vested in port sanitary authorities.

#### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 13th, 1904.

#### CANCER OF THE BREAST.

THERE exist two kinds of cancer, says Professor Mauclair: encephaloid and scirrhus. Two other affections in the cancer group must be detached, sarcomata and cysts. Encephaloid cancer is characterised by an insidious and painless *début*, wherein lies a grave danger, as women do not take much notice of it, and in the meantime the tumour develops both in depth and in surface. The adhesions it contracts with the skin produce the classical orange-peel appearance.

Soon the nipple retracts, ganglions appear in the axilla, and the skin ulcerates. It is necessary to diagnose at the outset such a grave affection, as the average duration is from eighteen months to two years.

Scirrhus is found generally in aged persons, while the encephaloid form attacks women between forty and forty-five years of age. The former constitutes a tumour of small dimensions, hard, producing atrophy of the gland. The duration of the malady is from ten to fifteen years. Either of these forms should be distinguished from numerous other affections of the

gland, firstly, *cutaneous epithelioma*, which is developed in the skin; the deep tissues are not affected, and the malady is easily recognised. Then comes chancre of the nipple, observed generally in young women; the tumour is round and the edges indurated. Syphilitic gummata can be found in the mammary gland, but the ulcerous and phagedenic character of the affection is sufficient to remove any doubts.

Other affections more rare might simulate cancer, such as submammary tumours (cold costal abscess, exostosis, lipoma), which push the gland forward. The same may be said of certain tumours which have been confounded with cancer. Cold abscess of the breast, mammary tuberculosis characterised by tuberculous granulations disseminated throughout the gland. *Cystic disease* of the breast, described in France by Reclus, is a bilateral tumour, symmetrical from the outset. The ganglions are not affected, and the affection remains stationary.

*Chronic mammitis* is one of the affections most frequently confounded with cancer. This malady appears, like the encephaloid tumour, at the close of uterine life, and is to be found in patients who had heretofore abscess of the breast. In palpating the gland from before backwards, small, irregular masses are felt, painful to pressure. Encephaloid cancer is not painful to pressure, is not bilateral, as is frequently the case with the chronic affection. The diagnosis is often difficult, and frequently only the treatment will clear up the nature of the affection. Elevation and compression by cotton wool of the breast produces improvement and retrogression of the masses in chronic mammitis, while no such favourable modification is ever observed in cancer.

*Adenoma* of the breast is easy to recognise. It is a little tumour which appears in young women; it is round, capsulated, and painful. Sarcoma is recognised at first glance. It is an enormous mass run over with a network of subcutaneous veins, and presenting cystic degeneration in places. The development is rapid, and no ganglions are found in the axilla. The prognosis is subordinate to the variety. Scirrhus can last twenty years, but it can also degenerate, hence the danger. The encephaloid form kills in two years, but there are many exceptions to this rule.

The treatment is naturally total ablation in both cases as early as possible, and by this means life is prolonged two or four years, or even more.

Another method of operating for cancer is ablation of the ovaries. According to M. Regnès, of Marseilles this operation is capable of producing retrogression of the tumours.

#### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 12th, 1904.

At the Naturforscherversammlung, Hr. Kövesi gave a communication on

#### DROPSY IN RENAL DISEASE,

based on observations made in the First Medical Klinik, Budapest. As regards its origin, there was no unanimity of opinion. After investigation of the tissue changes and cyroscopic examination of patients in Kóran's Klinik, it was believed to lie in the deficient excretion of water. For the purpose of the functional testing of the kidneys he recommended the dilution investigation (*Berl. kl. Wochenschr.*, Bd. 15, 1900), which rendered it possible to test the power of the kidneys to eliminate water. The organism with renal disease had no power of compensating the deficiency in the excretory power in any extra-renal way, therefore paralysis of the water-secreting apparatus caused retention, thus storing up fluid in the body. The retained water associated itself with the blood. It must therefore cause hydræmia. It might be assumed that the wall of the capillary vessel offered a certain resistance to heightened filtration pressure, which must be overcome before dropsy can arise, but it was not the only

factor. When the tissue was damaged in its elasticity in consequence of the burdensome high pressure, its power of forcing the tissue juices into the lymph tracts was also injured. In cases of mechanical blocking of urine special conditions prevailed, in consequence of which the cases ran a tolerably monotonous course without œdema and without any typical uræmia, but generally with symptoms of increasing bodily and mental decay. This subject had, however, not been much inquired into, and for this reason no decisive importance had been given to it. No cases of œdematous nephritis were observed in which any essential limitation of the dilution fluid could not be determined. Occasionally, in cases of nephritis, œdema of inflammatory origin independent of the typical insufficiency of elimination might be met with. The typical nephritic œdemata, however, were independent of the kidney condition. Considered from the clinical side, the secretion of water and the capacity of dilution of the kidneys outside the condition of these organs themselves depended on functional power of the heart. The speaker considered the genesis of dropsy, both in renal and cardiac diseases, to be the same. He attributed dropsy from heart affection to renal stasis due to hydræmic plethora and favoured by diminution in the rate of flow of the blood.

Hr. Kretz, Vienna, spoke on

#### CIRRHOSIS OF THE LIVER,

and said it was not dependent on interstitial hepatitis, but the parenchyma itself had become changed by regenerative healing of multiple attacks of degeneration. The appearance of elastic fibres in the connective tissue of the cirrhotic liver was essentially dependent on the fresh melting together of parts of parenchyma with free arterial supply, and already built around or walled in. The first anatomical change did not lie in the connective tissue, but in the patch-like degeneration of the parenchyma and in the subsequent wedging in of regenerated tissue in the region of the section of parenchyma with a better arterial supply.

Cirrhosis of the liver was not a morbid entity; the liver change was rather an anatomical sequence of repeated degeneration of liver cells with parenchymatous new growths thrust in between. Etiologically, the disease might be set up by any of the pathogenic influences that caused degeneration of the parenchyma; by abnormal tissue changes, by poisons, by bacterial injuries, and the injurious substance might reach the liver cells either by way of the blood tracts or by the bile capillaries.

Hr. Naunyn, Strassburg, had come to the following conclusions. There were distinctly various forms of the disease. It was well to distinguish (a) commencing cirrhosis; (b) the common ascitic cirrhosis (the atrophic form); (c) biliary (hypertrophic) cirrhosis; (d) the hypersplenic form of Banti's disease. The difference of these forms did not rest on any original difference in the morbid process, but on the complicating cirrhotic cholangitis, which was present in varying degree and in the most varied manner. This cirrhotic cholangitis was an enterogenous ascending cholangitis; it was not the cause of the cirrhosis but a complication which affects the organ already cirrhotic. The separation of enterogenous and splenogenous forms had no basis of fact, but, on the other hand, the hæmatogenous origin was probable. There might be hæmolytic processes in play, and if a cirrhotic cholangitis was present it would be a descending cholangitis of hæmolytic origin.

Hitherto only the alimentary leucosuria was recognised as a symptom of disturbed hepatic function, but even of this it has not been proved that it cannot be caused by the direct entrance of sugar into the blood. Diagnostically, therefore, characteristic anatomical changes were requisite. Lichtenstein's præcirrhotic splenic tumour was not proof of the "up-to-the-present-not-diseased-condition." Banti's disease was not specific. The cases resembling biliary colic were caused by infectious inflammation of the bile passages. Etiologically, alcohol was almost the only substance to be accused. The changes found by Bleichroeder were only consequences of the liver disease.

Aufrecht said there was only an apparent increase in the connective tissue, and this was caused by shrinking of the acini. Chiari, Prague, laid stress on the enormous new growth of the liver parenchyma, and also the interstitial secondary processes—frequently necrosis of the liver. V. Hansemann, Berlin, considered the alcoholic origin of the disease still undecided.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 12th, 1904.

#### QUANTITATIVE ANALYSIS OF BLOOD OXIDATION.

At the meeting of the "Naturforscher," Jolles presented a report on the analysis of blood and its catalytic power for oxidising. In this investigation he was assisted by Dr. Oppenheim who provided him with an extensive supply of clinical material. The principle of this analysis is founded on the comparative changes that take place in hydrogen peroxide ( $H_2O_2$ ).

His method of procedure is to take 0.05 cubic centimetre of blood in a capillary tube and place it in a measured 50 centimetres flask with 30 cubic centimetres of a physiological salt solution. The tube is finally rinsed out with another 20 cubic centimetres of the salt solution, making up the flask to the 50 centimetre mark. Ten centimetres of this blood solution is now mixed with 30 cubic centimetres of the peroxide of hydrogen, and the mixture allowed to stand for two hours at summer temperature. The next process is to acidify with  $H_2SO_4$ . Add a few drops of an iodide of potassium solution, and then titrate with the thio sulphate solution. The difference obtained between the 10 cubic centimetres of the blood solution, or 0.01 of the blood and a peroxide of hydrogen solution ( $H_2O_2$ ), will give the catalytic power of the blood. This catalytic number will be found to range between 18 and 30 in normal blood, but more commonly between 20 and 26. Male and female blood do not differ, neither does the arterial differ from the venous.

In special diseases, however, like tuberculosis, nephritis, and carcinoma, the value falls to between 1 and 10. This may be of considerable clinical value in cases of doubt, and where confirmation is required.

#### TESLA'S CURRENT IN TUBERCLE OF THE LUNG.

Stenbeck drew the attention of the meeting to Tesla's current in cases of pulmonary tuberculosis. Doumer, Oudin, and others had obtained good results according to their descriptions, but he was now convinced from long experience that the current must be very strong before any beneficial effects can be realised.

The so-called "effluvien" must be 15 or 30 centimetres, or about 6 to 12 inches, to be of any use, while the "inductorium" should be 50 to 60 centimetres for a spark. Without change of residence or food these cases when so treated take on body-weight and subjectively seem greatly improved. Notwithstanding this favourable result, it would be premature to form any conclusive judgment on the point.

#### INTERNAL EFFECTS OF FORMALDEHYDE.

Jakobson gave a history of the drug and its physiological effects on the human organism. The best way of administering the remedy was with sugar or milk, which relieved the irritation. In his own experiment 31 per cent. of the drug administered passed off by the kidneys, the rest being decomposed into formic acid, carbonic acid, and the remainder entering into combination with albumen.

Rosenberg said that he had used formaldehyde in many hundreds of cases without a single bad result, although his treatment ranged over angina, scarlet fever, diphtheria, erysipelas, and cystitis. The dose prescribed never exceeded 1 to 2 decigrammes per day in the form of a 1 per cent. solution, with milk of sugar, or in tablets.

Weintraud remarked that formaldehyde forms an insoluble combination with urea and uric acid, which



may explain the poor results obtained from citarin where it is in combination with an alkali.

Stern said that he had used large doses of urotropin, and never could find formaldehyde in the blood serum.

Müller observed that although it was true the elimination of uric acid was checked, the action on calculi in the bladder was powerful. Gout was not benefited by its use.

## The Operating Theatres.

### NORTH-WEST LONDON HOSPITAL.

**OPERATION FOR SYPHILITIC STENOSIS OF THE LARYNX.**—Mr. MAYO COLLIER operated on a case of stenosis of the larynx, that first came under his care some ten years ago. He said this was a unique case of its kind. The patient, a female, æt. 28, had presented herself at his out-patient's department ten years ago complaining of extreme difficulty of breathing. The history of the case was the following: She had been married four years. Six months afterwards she had been affected with a secondary eruption and a sore throat, and subsequently gave birth to a child that died in early infancy. Since then she complained continuously of laryngeal troubles, associated with cough and expectoration of blood-stained sputa. On examination it was found that the whole of the upper opening of the larynx was occluded by a cicatricial membrane leaving but a small opening, the calibre of a lead pencil, near the root of the epiglottis; the epiglottis itself had disappeared and was now represented by a stump the size of a small pea. Mr. Collier ascertained the woman had been affected with syphilis in early matrimony, the husband having suffered from well-marked syphilis. The then condition had been brought about by an attack of acute laryngeal catarrh, rendering the extremely limited opening for respiration still further curtailed. The case was immediately admitted into the hospital and tracheotomy performed. Mr. Collier said that at the end of fourteen days the patient left the hospital wearing a tracheotomy tube, which afforded satisfactory space for respiration. On two subsequent occasions the patient was re-admitted into the hospital, and an attempt was made to enlarge the stenosed upper orifice of the larynx. Under cocaine on both occasions an incision was made to the right and left of the stenosed orifice; the cicatricial tissue was so firm and rigid, however, that no increase of space was obtained. The patient now presented herself, having worn a tracheotomy tube for nine years, and having in the interval acted in the capacity of cook in various establishments, complaining of difficulty of breathing, difficulty of replacing the tracheotomy tube, and serious hæmorrhage at each attempt. Mr. Collier dilated on the importance of this case, and the fact that the patient had been quite comfortable for some nine years without any attacks of laryngeal catarrh or bronchitis, and had been continuously in domestic service during the whole of this period. With a good light and with the assistance of a pair of dilators he demonstrated to those around a mass of granulations not only extending into the trachea but surrounding the outer opening of the tracheotomy wound. He demonstrated with the laryngeal mirror the upper opening of the larynx, which apparently was unaltered since his first examination some nine years ago. It was now, as then, of the size of a cross section of an ordinary lead pencil. He said that this case was most encouraging so far as the operation of tracheotomy was concerned. The

patient had been able to change the tracheotomy tube daily, and had enjoyed a period of comparative comfort for some nine years. It was, he thought, astonishing that the granulations round the tube should not have given trouble before this. After placing the patient in a semi-recumbent position, with the aid of a good light he introduced a 20 per cent. solution of cocaine and adrenalin into the tracheal wound; with the aid of a pair of tracheal dilators he demonstrated to those around a fringe of polypoid granulations invading the tracheal canal; externally a similar mass of granulations on a level with the skin was equally apparent. He next introduced a curved Jarvis' snare, and removed the granulations one by one in each direction. The external granulations were removed with a pair of scissors and forceps, and a large-sized silver tracheotomy tube introduced, and the patient returned to bed. Mr. Collier remarked that in these cases of syphilitic stenosis of the larynx the patient in the course of time did not improve, for, as a rule, the stenosed orifice became more occluded and there was a great tendency to cicatricial contraction of any opening made into the trachea or elsewhere. He intended to retain this patient in the hospital till she was able to wear a silver tracheotomy tube of the largest size before discharging her; after which it was possible she might go another nine years without further surgical assistance.

**POLYPUS OF THE RECTUM.**—The same surgeon operated on a girl, æt. 14, who had suffered for the last four or five years from rectal irritation associated with a discharge of bloody mucus. The history of the case was that the child had complained of some irritation about the rectum and bladder for several years, there had been frequency of micturition, with pain and tenesmus after stools for a considerable period. Examination showed a polypus about the size of a filbert nut attached to a long pedicle, which was hanging from the right wall of the rectum. Mr. Collier pointed out that in this case the sphincter ani was apparently quite inert, the finger could be introduced with the greatest ease, and the polypus withdrawn. He withdrew the polypus with a pair of catch forceps, applied a ligature at the base of the pedicle and removed it with scissors. He remarked that this was an unusually typical and simple case, and required no after-treatment or dressing. He said the condition of the sphincter ani was apparently due to the presence of the polypus within its lumen.

### A New Scholarship for Pharmacy Students.

MESSRS. FAIRCHILD BROS. AND FOSTER, of New York, in order to mark their "appreciation of the friendly relations which have existed for many years between the firm and the pharmacists of this country," have inaugurated a scholarship of the annual value of £50, with consolation prizes of £5 each, to be awarded to the *proxime accessit* in each country—England, Ireland, Scotland and Wales—the examination centres being London, Manchester, Dublin, Edinburgh, and Cardiff. The first examinations will be held simultaneously in July next year. Candidates must be between twenty and twenty-two years of age, and duly registered and affiliated to either the Pharmaceutical Society of Great Britain or the Pharmaceutical Society of Ireland. The subjects of the examination are simply those with which the student would be expected to have ample acquaintance in any reasonably equipped pharmacy. Further particulars may be obtained by application to the secretary of the Committee of Trustees, A. E. Holden, Bath House, 59 Holborn Viaduct, London, E.C.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 16, 1904.

**THE ABUSE OF HOSPITALS.**

THE complaint against hospital abuse is as old as the hills, and the demand for its reform dates from a period prior to the birth of medical journalism. In spite of the lapse of years, however, no great practical step has hitherto been taken towards putting a stop to the evil in question. The *crux* of the whole matter lies in the fact that the medical charities are controlled by philanthropists who are not in touch with the main body of the medical profession, while the honorary medical staffs of those institutions apparently know little, and care less, about the practice which their gratuitous service abstracts from outside practitioners. If the hospital surgeons and physicians generally took up a firm and sympathetic position upon the whole subject, we believe that within a week the question of hospital abuse could be reduced to a satisfactory basis of settlement throughout the United Kingdom. That proposition we commend to the notice of Mr. F. Harris White, the energetic secretary of the East London Medical Society. As most of our readers will doubtless remember, while others have been content to sit still and grumble, the Society in question has brought matters to a head by a polite but insistent criticism of the way things are conducted at the London Hospital. That particular charity is no better and no worse than other institutions of the kind, but it provides for an enormous population, and happens to fall within the field of operation of the Society of which Mr. Harris White is secretary. Last May a deputation of that body waited on the Board of Management of the London Hospital to ask for reform of certain abuses in the administration of relief. The first great step gained was an admission of the existence of the abuses complained of, although they had previously been repeatedly denied in the public press by prominent members of the London

Hospital Committee. The Medical Society's complaint fell under the two heads of the system of part payment by patients and of want of scrutiny as to means of applicants for relief. The hospital authorities admitted the existence of abuses, as already stated, and, further, that in the casualty room scrutiny was non-existent. The precautions now adopted seem good, so far as they go, but, while not abandoning the part payment system, they put up notices stating that patients' payments are for dressings and other value received, and not for medical advice. Other steps include the obviously essential one of registering the address of patients, which the authorities place at the disposal of local practitioners who may wish to inspect them. It seems clear, however, that no hospital should be permitted to shirk its responsibilities by thus foisting a system of espionage upon the members of an honourable profession. It is the hospital that sins in giving charitable aid to the well-to-do and not the outside general practitioner. A similar objection applies to the offensive and grotesque suggestion of the hospital that outside medical men should visit the out-patient departments in order to detect unsuitable patients. This proposal is in itself sufficient amply to illustrate and to emphasise the contemptuous attitude of hospital philanthropists in countering the home-thrusts of an injured profession. Fortunately, the East London Medical Society is able to press a skilful as well as a strong attack where generations of unorganised protest have failed to make the faintest impression. The hospital next proposes to send patients who can pay small fees to the Metropolitan Provident Dispensary over the road. This cynical evasion of a just demand certainly does not add to the respect to which the London Hospital management should be entitled, and we trust they will abandon this unworthy suggestion. They propose to call in the aid of the Jewish Guardians and of the Charity Organisation Society to exclude unsuitable patients. The latter body is certainly likely to drive away patients, but we were under the impression their help had been secured years ago by the London Hospital. The most reassuring proposal by the committee is that the home of every patient should be visited the day after admission, and if found to be unsuitable he or she is to be discharged and a donation demanded on behalf of the hospital. This sounds well if it could be made practicable in so large an institution. The upshot of these negotiations will, we trust, be an amicable working agreement between the London Hospital and the medical profession of East London. Should that happy result not follow, it is possible for the members of the Medical Society in question to bring pressure of a most convincing and effectual nature on the consulting surgeons and physicians of the honorary staff of the hospital, as we have already pointed out, in whose hands the key of the situation most undoubtedly lies. The honorary staff is to a great extent dependent on the goodwill and friendship

of the outside general practitioner, and the work of the hospital depends on the gratuitous services of the medical and surgical staff.

#### MUSIC AND MEDICINE.

THE field of therapeutics is rapidly widening, and the resources of every art are being continually tapped to add to the weapons of the physician. "Sweetness and light" have to a great extent supplanted nastiness and draughts in the treatment of disease, and the patient of to-day may console himself amidst the trials of modern life with the reflection that his lot in the hour of sickness was not cast in the "good old times." To bring music into requisition as a means of dealing with the sick has long been hankered after by one person and another, but beyond the now orthodox asylum band, little progress has been made in the application of sweet sounds to disturbed bodies and brains. The subject is, however, being taken seriously in hand by a certain body named the St. Cecilia Guild, who have mapped out an ambitious programme for themselves. They propose first to study by investigation the extent of the influence of music on the heart, blood pressures and respiration; at least, that is the initial item mapped out in their prospectus. We do not wish to damp their enthusiasm, and we shall be very glad if they are able to add anything useful to medical knowledge as the result of these investigations, but we rather fear that the line of research that they are proposing to follow will prove a somewhat barren one. True, Dogiel has announced in his work, "Experiments on Men and Animals," that music is capable of raising or depressing the blood pressure under varying circumstances—such as the disposition and susceptibility of the subject, and the nature of the music performed—and he has found also that the pulse- and respiration-rates were affected under the same conditions—a result attributed to the influence of stimulations of the auditory nerve acting reflexly on the vaso-motor nerves through the sympathetic system. Without gainsaying the accuracy of these statements, it has yet to be shown that the influence of music is sufficiently potent and durable to produce effects on sick people that are of practical utility. Music can undoubtedly make a strong appeal to the emotions of sympathetically-attuned persons, but its influence soon passes off, and is not in bulk much greater than that exerted by the reading of an exciting or soothing story-book. The St. Cecilia Guild, however, seem to have made up their minds on the therapeutical utility of music, for their second object is to organise a body of special musicians, vocal and instrumental, who will be available at any time of the day or night to attend on patients at the doctor's order, and perform music of the character he prescribes. No doubt can exist as to the enthusiasm of a player who is ready at a moment's notice to turn out of bed to perform Beethoven's Moonlight Sonata or to recount the vagaries of Bill Bailey according to the

whim of the invalid or the fancy of the doctor, but we are inclined to think that in the present state of medical opinion the slumbers of the members of the Guild and that of the patients' neighbours are not likely to be seriously encroached upon—in this country at least. In order, however, to obviate any remonstrances from disturbed and unappreciative persons, an alternative course has been devised, namely, to establish some central building for the continuous performance of music which can be enjoyed by telephone or electrophone by the sufferer in his bedroom. This plan is certainly open to less objection, but there is something rather pathetic in the idea of these willing ministers to the sick discoursing music, with an infinity of expression and care, without knowing whether or not they are being listened to, or if their performance is one that is suited to the patient's particular case. For, if music is to be beneficial in its effects, the first consideration is that it should be appropriate to the state it is desired to induce. "Bill Bailey" might act as a charming lullaby to a Cockney child, but there are others who would find it positively irritating. If that were the item selected for continuous performance through the telephone on any particular night, some sufferers, at least, would find sleep further off than ever after listening to its haunting melody. Dr. Kennedy, of Brooklyn, believes that the field of action of music reaches into all departments of medicine, including surgery and dentistry, and would have the occupant of the dental chair soothed and sustained by the quieting influence of music. In a paper read before the Medical Society of King's (N.Y.), he warmly advocated the extended use of music in the treatment of the sick, and gave demonstrations of the methods of administration and of the effect music of a certain character might be expected to produce. Perhaps the most practical suggestion that has been put forward as yet is that music should be used as an adjunct to anæsthetics, calming and diverting the patient's mind till consciousness is lost. It is said that a number of test cases have been treated by this method in Germany, and that there was absence of distress and resistance on the part of the patient, and also absence or reduction of nausea and sickness following the operation. This is good news, of course, but most medical men will hope that the fact may not become too widely known. The paraphernalia of the anæsthetist are sufficiently cumbersome already without his having to add a gramophone or musical-box to his equipment. The real fact would seem to be that the use of music as a therapeutic agent is but a small one, and though it may have some use as an ancillary, it is not likely to have much as principal agent in the treatment of patients.

#### Notes on Current Topics.

##### Paिताosis.

DOMESTIC animals are not always unadulterated blessings, and unless well watched and cared for

may become sources of infection to the household in which they live. Cats may convey diphtheria; dogs give rise to worms, whilst birds have been suspected of tuberculous leanings. Vickery (a) quotes several outbreaks in households of a condition remarkably like typhoid in which the infection probably originated from parrots. The disease, as a rule, sets in sharply with febrile symptoms, but the onset may be insidious. The fever is continuous and ends by lysis; constipation is usual, but there may be diarrhoea; enlarged spleen is invariable and a roseolar eruption may be associated with it; whilst foci of pneumonia commonly are found in the lungs. Vickery himself has met with a group of three cases of such an illness, which followed the arrival of a parrot in the house. The bird suffered from a bloody diarrhoea, and died, passing the time of its illness in one of the sitting rooms. There were four members in the household, and of these the only one not affected had little to do with the bird. The first patient was the servant who looked after it, and she sickened eighteen days after the parrot's arrival; the other two victims followed in a few days. From the descriptions given of psittacosis, Vickery is of opinion that his cases should be placed under that heading. The bacteriological examination results were indefinite, but none of the ordinary recognisable organisms were found. As the bacteriology of psittacosis is doubtful, the findings were so far in its favour. It is always well to inquire after the health of domestic pets when any member of a household is taken ill from obscure causes, and even the parrot in his cage should not escape the general suspicion.

#### Clever Malingering.

THE man Cecil Brown Smith, sentenced to three months' penal servitude last week at the Guildhall for collecting alms under false pretences, is quite a notable figure in the annals of crime. His career of late years presented one of those extraordinary patchworks that we are accustomed to associate with a certain class of criminal—obtaining money under false pretences in the day, leading a respectable domestic life at home in the evening, and varying these proceedings with playing billiards, visiting places of entertainment, and preaching at Salvation Army meetings. But the real interest of the case from the medical point of view was his imitation of paralysis. Some time ago Smith had an accident and declares that, as the result of this, he suffered from paralysis of the right side. That he did so is not very clear, but he was certainly an inmate of St. Thomas's and afterwards of the National Hospital for Paralysis. Whatever was wrong with him at the time he recovered sufficiently to enjoy himself after his manner soon after coming out, and whilst in hospital he had learned a profitable way of earning a living. This was by feigning right hemiplegia—as he had seen it in the wards, and posing as a paralysed beggar in the City. His

imitation is said by those who saw him to have been wonderful, the side of the face being drawn down, the right arm and hand stiff and rigid, and the right lower limb dragged wearily along. So good was his impersonation of the part that he was freely made the recipient of alms by generous passers-by, and he earned upwards of six pounds a week by the deception. Even when examined by the surgeon at the police-station he was not non-plussed, as he had noticed in hospital the tests applied to patients for purposes of diagnosis, and how to counterfeit the responses of those who were really diseased. It was only when he found the game was up by the appearance of witnesses who had seen him in full possession of his powers that he shook off his paralysis and appeared in the dock in his natural active condition. His case was certainly one of the most successful and—if we may say so—artistic in the history of malingering.

#### Municipalities and Bacteriology.

As our readers are aware, many of the more progressive municipalities, at home as well as abroad, have seen fit to undertake the bacteriologic examination of suspected clinical material, thereby giving aid to the practitioner in his labours on behalf of the public health. Liverpool, Manchester, and many other cities have appointed bacteriologists whose duty it is to examine material sent to them by any medical man in the town. For instance, in Manchester, every practitioner is supplied by the Medical Officer of Health with apparatus for the transmission of sputum, diphtheritic membrane, blood for the agglutination test, and so on, and he is encouraged to ask the help of a skilled bacteriologist retained by the city in such questions of diagnosis. The question of the appointment of a bacteriologist to the City of Dublin has been under discussion now for some time, the Public Health Committee having recommended such an appointment. Dublin can certainly not afford to overlook any precaution which might improve the public health, as it still maintains its pre-eminence as almost the most unhealthy city in Europe. It is, moreover, decimated by tuberculosis, and the early diagnosis of phthisis would undoubtedly tend toward the public good. Nevertheless, the Dublin Corporation has decided to postpone the question for two years. This decision is all the more culpable as the expense would be inconsiderable. There are several laboratories in Dublin, public and private, with any one of which it would be easy to arrange the examination of clinical material at moderate rates, and where the payment could be arranged, either at a fixed sum per annum or in proportion to the work done.

#### Recent Appointments at the Royal University.

THE Council of the Royal University Graduates' Association, an association which appears to be almost entirely limited to Belfast graduates, have adopted a strongly worded resolution in protest against the manner in which the recent vacancies

(a) *Med. News*, October 22nd, 1904.

on the Senate of the University have been filled. The resolution is as follows:—

"We, the Council of the Royal University Graduates' Association, desire to express our deep sense of indignation at the grave injustice inflicted upon the North of Ireland by the Irish Government in their recent appointments to the three Crown vacancies on the Senate of the University. Notwithstanding the fact that the Belfast Medical School contributes more than half of all the candidates in the Faculty of Medicine, the Irish Government have appointed as successor to the late Dr. W. A. M'Keown, Sir W. Thomson, a Dublin surgeon, who does not represent any school connected with the University, and whose appointment leaves the Belfast Medical School without a single life representative on the Senate or on the Medical Committee. We regard the selection of Sir W. Thomson as a studied slight to graduates of the University, in view of the fact that during the time he represented the Convocation on the Senate his policy was objectionable to the graduates, and recently when he sought reelection he was defeated by a large majority. The Council cannot but consider that the action of the Government is a retrograde departure from principles on which the University was established, and a deliberate attempt to neutralise the very meagre influence originally bestowed upon the Convocation by the Crown. The Council, therefore, are reluctantly forced to the conclusion that the Government, by their depriving the large and important community whose views the late Dr. M'Keown so ably advocated of a representative on the Senate, are deliberately endeavouring to promote a spirit of discontent with the present University system, in order the more effectively to crush opposition to any future proposals to introduce the denominational element into University education in this country."

If, as is stated here, these appointments mean that the Belfast Medical School is left without a representative on the Council, we have no hesitation in expressing our opinion that the School has been treated unfairly.

#### Physical Culture.

ONE of the crazes at the moment is for physical culture, and various instructors in the art are kept busy teaching weakly youths and corpulent gentlemen how to attain the proportions of Apollo and the bloom of health by a few simple exercises. Far be it from us to deny that such a movement is both wholesome and health-giving, and far more desirable than many of the silly fashions that periodically seize people with more money than brains, and more imagination than common sense. The appetite for physical betterment has been carefully whetted by various devices, and physical culture schools are now among the most paying investments for brawny men with a modicum of brains. But as inevitably happens with all craftsmen who deal with the human body and who acquire a circle of clients, the temptation to leave the latter and enter into a wider sphere of practice has become too great, and these professors of physical culture have—some at least of them—yielded to it. One of the best-known of these teachers has lately taken large offices—and advertised

that he can treat dyspepsia, constipation, insomnia, and various other ailments by his method, and that this treatment can be carried on by correspondence, and so arranged that the sufferer can, at small cost and without interference with his ordinary avocations, effect the cure in his own bedroom. As medical men in the past have been disposed to look not unfavourably at the physical culture movement, and some have even sent patients for a course of exercise under its exponents, it behoves them to notice to what use their patronage has been put, and what its effect has been. In future we think they will be well advised to inquire into the methods adopted by any teacher they recommend, and to give a wide berth to those who, besides and beyond their legitimate business, advertise to treat and cure diseases. As the world wags every man seems to think himself endowed by Nature with the gift of healing, a delusion which the law assists by confining its attention to legally qualified practitioners of medicine, while a horde of quacks are allowed to prey on the public unhindered.

#### The Heart in Diphtheria.

THE poison of nearly all the acute specific fevers seems to focus itself with special intensity upon the vascular system and upon the heart in particular. The early and also the remote effects of typhoid fever upon the circulatory system are of great clinical importance, and scarcely less so are the various morbid conditions of the heart that may be met with in the course of true diphtheria. How many times has not a suddenly fatal collapse occurred during apparent convalescence from this disease simply owing to the slightly increased strain thrown upon the heart in the act, say, of sitting up in bed! Nor has cardiac weakness or actual organic disease always been a marked feature in such cases. Much may be learnt concerning the cardiac complications of diphtheria from a valuable communication by Drs. Franklin White and Howard Smith, (a) of Boston, U.S.A., who have made a study of 946 cases of this affection with special regard to its effect upon the heart. These observers have found that irregularity of the pulse occurred in 60 per cent. of all the cases, this being more marked in young patients. Of the cardiac murmurs which were present, the majority developed within the first few days of the illness, lasted several weeks, and in 78 per cent. they were present at the time of discharge. Acute, sudden cardiac dilatation was not common, all the fatal cases showing a gradual heart failure. Slowness of the pulse was rare, but extreme bradycardia often heralded a fatal issue. The most important sign of organic heart disease in diphtheria is stated to be the presence of the galloping rhythm, and following this, the appearance of vomiting is to be regarded as of ominous import. This latter symptom would seem to indicate vagus degeneration, and in a few cases this has been found *post-mortem* by Councilman. Frequent examination

(a) *Boston Med. and Sur. Journ.*, October 20th, 1904.

of the heart is necessary, and in all cases more or less prolonged rest in bed is advisable, especially when the pulse remains persistently rapid.

#### The Jubilee of Modern Nursing.

THE life of the present generation has been so completely in the age of scientific nursing that it is only the older among us who remember a time when the trained nurse was not. Her position is now so well established—second only to that of the medical adviser himself—that we find it hard to realise that it is only fifty years to a few days since the first band of English trained nurses was organised by Miss Florence Nightingale. In 1847 a request was published for nurses to volunteer for service in the Haslar Naval Hospital, but not a single volunteer appeared. In 1854, when the Crimean war had been some months in progress, it was borne in on the authorities that the sick and wounded soldiers were not receiving the care they should, and Miss Nightingale, who had some years before undergone a year's training at Kaiserswerth, was invited to organise a nursing service. She arrived with her band of thirty-seven nurses at Scutari on November 5th, 1854, and from that date begins modern English nursing. It would be waste of paper and ink to draw attention in detail to the revolution in the treatment of the sick which has taken place since then. The system inaugurated by Miss Nightingale has been the basis, not merely of every system of military nursing, but of the care of the sick as practised to-day in every civilised country. Of Miss Nightingale's life-long interest in the profession she created it is equally unnecessary to speak. Her donation of the testimonial presented to her by the nation in 1857 to the foundation of a training school for nurses in connection with St. Thomas's Hospital is merely one example of this interest. The medical profession is glad to join in congratulations to one to whom suffering humanity owes much.

#### A New Dental Journal.

WE are glad to notice the arrival of a weekly paper, the *Dental Surgeon*, devoted to the interests of the dental profession and the study of dental science. It is sure to meet a distinct want, for, however excellent may be a monthly or quarterly review, it contains a different kind of material, and calls for a different kind of reading from a weekly newspaper. The standard of education in the dental profession is being steadily raised in recent years, and the practitioner takes a wider interest in the doings of his fellows than formerly. A weekly paper which, in addition to articles of scientific value, gives in interesting fashion items of passing news, should appeal to a wide audience. It is of importance, too, that there should be a free medium for discussion on the various political questions which are of interest to our dental brethren. Even more than ourselves, they suffer from unqualified competition, and the competition of companies, while there are various

ethical questions, such as the permissibility of advertising, which have yet to be settled. The first number of our contemporary is bright and interesting, and we have pleasure in wishing our youngest contemporary a long and useful career.

#### The Surgeon's Post in French Duels.

THE recent disgraceful assault on General André, an old man, in the French Senate, has led to a crop of duels. Needless to say, these encounters were for the most part void of bloodshed, although by an unforeseen accident one of the combatants sustained a cut in the wrist. It is to be hoped that the wounded hero will treasure—for the rest of his life—the lesson gained by his bloody experience, so that in succeeding duels he may treat the cold steel of his adversary with distant respect, according to the fashion of his cooler-headed countrymen. An even more terrible experience awaited the surgeon in attendance at one of these duels. The fight was to be settled with pistols, and he stood midway between the duellists at what he thought to be a safe distance. At the first discharge both bullets whistled close to the head of the surgeon, who thereupon retired several yards further from the zone of fire. In vain, however, was his strategy, for on the next exchange of shots one cut through the brim of his hat and the other grazed his knee. The surgeon then beat a precipitate retreat from the field of battle. Clearly the safest plan for him, if he ever summons up enough courage to attend another duel, is to insist upon both duellists aiming at the surgeon. The medical profession is one of peace, and it would be a pity to deprive it of one of the few opportunities of figuring in warlike events by neglect of a few commonsense regulations that could readily be framed by anyone conversant with the French duel.

#### The Aldershot Poisoning Outbreak.

THE origin of the wholesale poisoning which took place last week at Aldershot still remains a mystery. A number of non-commissioned officers and men—according to some accounts not less than a hundred—of the Yorkshire Light Infantry, were attacked with sudden sickness and prostration, but we are glad to learn that all have made a rapid recovery, with the exception of a corporal, whose condition was at one time critical. The nature of the illness and the history of the outbreak point with unmistakable directness to the source of the mischief in some form of food-poisoning. Indeed, a circumstantial account has already been circulated in which the irritant has been traced to an Irish stew which the men had for dinner on Thursday last. It is said that those who ate roast meat, the alternative dish, escaped the attack. If the stew is proved to have been at fault, it still remains to be found out whether the case is one of ptomaine poisoning from bad meat, or one of contamination from metallic or unclean cooking vessels. The whole matter is to be sifted to the bottom by a Board of Officers summoned by the Principal Medical Officer to



investigate the affair. The rarity of occurrences of the kind go far to prove the absolutely careful supervision of food and of kitchens that must be in force in our great military camp at Aldershot.

## PERSONAL.

THE list of Birthday Honours includes the names of four members of the medical profession, upon whom the honour of Knighthood has been conferred by His Majesty the King.

PROFESSOR WILLIAM JAPP SINCLAIR, one of the recipients, the well-known Manchester physician, is fifty-eight years of age. He is M.A. and M.D. of the University of Aberdeen, and is at present Professor of Obstetrics in Manchester University. He withdrew from the Liberal Party in the Home Rule split in 1886.

DR. CHARLES HAYES MARRIOTT, J.P., another of the new Knights, began his connection with Leicester forty-four years ago by becoming house surgeon at the local Infirmary. He resigned the honorary surgeoncy of that institution in 1901.

SIR SHIRLEY MURPHY, as he now becomes, has long been prominent in public health work. Educated at Guy's Hospital, he became a member of the English Royal College of Surgeons in 1870. He has been Lecturer upon Public Health at St. Mary's Hospital School, and among other distinguished posts has been President of the Society of Medical Officers of Health. His most important post has been that which he now fills with distinction, namely, that of the Medical Officership of Health of the Administrative County of London.

MAJOR ALLEN PERRY, the fourth Knight, took his various medical degrees between 1884 and 1892. He was for three years at the Royal Westminster Ophthalmic Hospital, and was then junior house surgeon at the Poplar Hospital for Accidents, and a house physician at the London Hospital. His present positions are those of Principal Medical Officer and Inspector General of Hospitals of the Island of Ceylon.

At the opening meeting of the Aberdeen University Medical Society, at Marischal College, on November 4th last, an interesting address on "The Medical Student and his Profession" was delivered by Mr. J. Scott Riddell, senior surgeon of the Aberdeen Royal Infirmary.

PROFESSOR CASH, F.R.S., on the 3rd instant, delivered his presidential address to the Aberdeen Medico-Chirurgical Society on the subject of dosage.

DR. E. H. TAYLOR has been appointed assistant to Professor E. H. H. Bennett, who now fills the Chair of Surgery in the School of Physic, Trinity College, Dublin.

A CIRCULAR letter, signed by a large number of influential medical men, has been issued in support of the candidature of Sir Henry Craik for the Parliamentary representation of the Universities of Glasgow and Aberdeen.

DR. JAMES BRISBANE will preside at the annual dinner of the Glasgow University Club in London, on the 23rd instant. Further particulars can be obtained of the Honorary Secretaries, 63 Harley Street, W.

THE distinguished recognition of a royal medal has been conferred by the Council of the Royal Society upon Colonel David Bruce, R.A.M.C., F.R.S., for his researches and discoveries in the causation of various tropical diseases.

PROFESSOR JOHN MCFADYEAN, M.B., B.Sc., Principal of the Royal Veterinary College, will deliver the Harben

Lecture on Glanders at King's College, 5 p.m., November 25th and December 9th. Members of the medical profession are invited.

DR. W. WATSON GLENNY, of Omeath, has been appointed to the magistracy of county Louth, and Dr. John McFadyean to a magistracy of Govan.

MR. ARTHUR H. TREVOR has been appointed Secretary to the Commissioners in Lunacy in the place of Mr. L. L. Shadwell, who has been appointed a Commissioner in Lunacy.

DR. A. D. CLINCH, of Clondalkin, has been elected President of the Irish Rugby Football Union. He is an old International player, and sometime captain of the Dublin University Football Team.

DR. T. GREGORY FOSTER, B.A., Ph.D., principal of University College, London, has been elected a representative of the College on the Senate, in the place of Dr. G. Carey Foster, resigned.

MR. H. T. BUTLIN, D.C.L., F.R.C.S., has been elected a representative of the Royal College of Surgeons of England on the Senate of University College, London, in the place of Sir Henry Howse, resigned.

DR. BASIL M. WILSON has entered the Civil Service of Fiji as a Government Medical Officer.

MR. CURTIS C. A. JONES has taken up duty as a Medical Officer of Lagos. He acts as an assistant in the general and medical sanitary work of Lagos town.

THE British Chaplain at Berlin, the Rev. J. H. Fry, recently opened a private hospital which has been founded on behalf of English and American patients desirous of receiving more individual nursing than that obtainable in the Berlin hospitals.

THE Committee of the Bristol Lunatic Asylum have appointed as the new superintendent in place of the late Dr. Benham, Dr. James Vincent Blachford, who has been assistant medical officer since 1896.

WE understand that Dr. W. H. Hamer has been selected as head of one of the branches of the London County Council public health department at a salary of £850, rising to £1,000, and an assistant medical officer will be appointed in place of Dr. Young, who has resigned.

THE King has been pleased, on the recommendation of the Secretary for Scotland, to appoint Dr. W. Leslie Mackenzie to be the medical member of the Local Government Board for Scotland, in room of Dr. Russell, deceased.

THE funeral of Dr. Vintras, principal physician of the French Hospital in London, will take place at the Church of Notre Dame de France. The French Ambassador will be present.

MRS. NOSWORTHY, of Newlands, Dawlish, has offered to defray the whole cost (estimated at ten thousand pounds) of the erection of a new operating theatre at the Royal Devon and Exeter Hospital at Exeter.

DR. R. H. FLEMMING has been appointed to the post of Gynæcologist to the Royal City of Dublin Hospital, in succession to the late Dr. J. L. Lane.

## The Mater Misericordiae Hospital, Dublin.

THE medical session at this hospital was formally opened on the 8th inst., when an interesting address was delivered by Sir Christopher Nixon, M.D., on "The Various Phases of a Hospital's Work." The address will be found in another column.

## Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

### SCOTLAND,

**PARLIAMENTARY REPRESENTATION OF THE UNIVERSITIES OF GLASGOW AND ABERDEEN.**—The Glasgow University Conservative and Liberal Unionist Association and the Aberdeen Unionist Association have issued a circular, dated November 8th, in reply to that recently referred to in this column, sent out by the Universities of Glasgow and Aberdeen Conservative and Liberal Unionist Association in support of the candidature of Professor W. R. Smith, M.D., who is opposing Sir Henry Craik, the official nominee of the party associations. The new circular states that Sir Henry Craik's nomination was decided on after careful consideration of both committees, on which the medical profession is largely represented. Sir Henry Craik was a Snell exhibitioner, and after leaving Glasgow University, went to Balliol College, gaining high honours at Oxford. In 1882, he was made LL.D. of Glasgow. His life has been devoted to educational work, first in the English Education Office, and subsequently as secretary to the Scottish Education Department, from the year 1885 (in which it was established) until the present time. His "recognised position as a man of letters, and his unique experience of the working of educational systems both of Scotland and England, peculiarly qualify him to represent a University constituency." Sir Henry Craik's Committee contains the names of a number of the medical profession, among others those of Sir Wm. Gairdner, Sir Hector Cameron, Sir Wm. MacEwen, Drs. McCall Anderson, Mitchell Bruce, Cossar Ewart, Freeland Fergus, David W. Findlay, Matthew Hay, Yule Mackay, T. G. McKendrik, and Samson Gemmel.

**AGE LIMIT FOR THE STAFF OF THE EDINBURGH ROYAL INFIRMARY.**—The special Committee appointed to deal with this question has just issued a long report which was submitted to the Court of Contributors on the 14th inst. We may recapitulate shortly, from the report, the circumstances which led to the appointment of the Committee. Towards the end of 1903, the managers of the Infirmary decided that the ordinary physicians and surgeons should be retired at the age of sixty-five, the rule not to apply to those serving their second or third term of five years in charge of wards nor to Professors. When this rule came before the Court of Contributors for confirmation, a motion was carried putting the professors on the same footing as the ordinary staff, but at the adjourned meeting this was in effect overthrown by the appointment of a committee to confer with a committee of the managers, and to report. This special Committee met on several occasions, and now report as follows:—The clerk of the Royal Infirmary made an exhaustive search through the minutes of the Infirmary, and prepared excerpts therefrom as to the relationship of the University and Royal Colleges to the Infirmary. These were printed and circulated to all interested parties, and it may be here stated that they indicate clearly that the professors hold their wards at the pleasure of the managers, and not under any right or agreement, and this has been admitted by the senators in a subsequent communication to the Committee, but hitherto professors have retained the charge of wards without question, so long as they continued to occupy their chairs. In reply to requests for an expression of their views on the subject, the Royal College of Physicians, the Royal College of Surgeons, and the Staff of the Infirmary favoured an age limit; the University was against it. The Committee then ascertained the rules and practice regulating the appointment of the ordinary staff, the number of wards and beds under the care of each member of the staff, the dates of appointment as assistants of the members of the ordinary staff, and of their subsequent promotion to full rank; and the dates of appointment of the present assistant staff. Having fully considered the whole question, the Committee think that a compulsory age limit is inexpedient, and

recommend (1) that the rule fixing an age limit be not adopted, (2) that accordingly the resolution requiring professors to retire at the age of sixty-five be rescinded, and (3) that in future each Professor and physician and surgeon in charge of wards may, on the expiry of his appointment, apply for reappointment, when the managers shall give careful consideration to his case, and when, if the managers deem it expedient, he may be reappointed for such term as they may fix. These recommendations will, the Committee think, render an age limit superfluous. In the case of the ordinary staff, an age limit of sixty-five, looking to past experience, would practically never become operative. Under the proposed rule the managers will have the special control of the duration of office of members of the staff, and professors, and will have it in their power to renew for five years, or less, or to resolve that there shall be no reappointment. The report, of which the gist is given in the preceding, is signed by eight members of the Committee. Two members dissent from the foregoing conclusions and recommendations, on the ground that in the interests of the patients and of medical and surgical science an age limit is desirable. It is to be presumed that the whole matter is now settled, though it awaits final confirmation of the meeting of the contributors.

### BELFAST.

**THE SMALL-POX EPIDEMIC.**—During the last fortnight nine more cases of small-pox have been discovered, and removed to the hospital at Purdysturn. Of these only one appears to be severe, the patient being a man of forty without vaccination marks or history of vaccination. Two cases have died during the fortnight—one an unvaccinated child, and the other a man of thirty-seven, said to have been vaccinated, but on whom no marks could be found. It is rather amusing to note that the present has been chosen as an appropriate time for an anti-vaccination campaign in Belfast. A series of meetings has been held during the past week, at which an imported lecturer has harangued small audiences, generally under the chairmanship of a member of the Board of Guardians. To judge from appearances, not much harm is likely to be done. The Belfast public has always got a fair amount of excitement out of its religion and politics, and has never taken kindly to the numerous fads which flourish so luxuriantly across the Channel.

**THE ULSTER MEDICAL SOCIETY.**—The opening meeting of this Society was held in the Medical Institute, Belfast, on Thursday evening, November 9th. Dr. John Campbell, who has been president for the past two years, having introduced his successor, Dr. William Calwell and vacated the chair, received a hearty vote of thanks, on the motion of Professor Symington, seconded by Dr. Hadden (Portadown). Dr. Calwell delivered an address on "Some Aspects of Metabolism, chiefly Clinical," which will appear in a subsequent issue of this journal. At the conclusion of the address, a vote of thanks was moved by Dr. J. Walton Brown, and seconded by Professor Lindsay.

The report of the Council stated that the annual dinner has been arranged for Saturday, December 3rd, when Sir Lauder Brunton will unveil the bust of Sir William Whitla, which has been executed for the members of the Society by Miss Kathleen Shaw. A number of guests from Dublin and from across the Channel are expected to be present.

## Correspondence.

### LOCAL SUPERVISION OF CERTIFIED MIDWIVES.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*  
SIR,—The success of the Midwives Act of 1902 greatly depends upon the efficiency of the supervision of the local supervising authorities appointed by the Councils of the Counties and County Boroughs throughout England and Wales, and also upon local efforts for assisting the midwives to acquire the knowledge

which is essential for the correct discharge of their new duties.

Up to the present time the midwives throughout the land have been carrying on their work without any restrictions, and it is a fact that the greater part of these women have never received any instruction or training, and are in every sense incapable and ignorant of their responsibilities. I have often been told by my medical brethren that many women who have been acting as midwives for years, and who have recently obtained certificates under Section 2 of the Act, do not understand that they are under strict local supervision and control, and that in every difficulty and in every deviation from the normal they are bound to send for professional assistance.

Now there must be urgent need, if these statements are true, for the development of a scheme to assist the existing midwives to learn their new duties, and to work in conformity with the provisions of the Midwives Act. Without help it is impossible for them to reach a standard of knowledge equal to their responsibilities. But how is this assistance to be provided? Surely it is a question which demands the serious consideration of all local supervising authorities, and there can be no doubt that in every large centre it will be easy for the local authorities to secure means for the enlightenment of the women placed under their control. Without such help, it will not be possible to speedily clear the lying-in-room of the ignorance, superstition, and sanitary impurity which have been the cause of the terrible mortality among the poor parturient women of our country. The instruction in elementary topics would prove a great boon to practising midwives, and it could be given by lectures, by oral examination, and by exhibiting the method of reporting the details of practice and of carrying on the work in accordance with the rules framed by the Central Midwives Board. I believe that in every area medical practitioners will be found willing to assist the local supervising authorities in this important object.

I have read with much pleasure the able address of Dr. Ewen Maclean, which he delivered at the University College, Cardiff, on the Education of Midwives, and I wish a copy of this valuable lecture could be sent to all the members of the County Councils throughout the country.

I am, Sir, yours truly,

J. WARD COUSINS,  
Representative of the R.C.S. of England  
on the Central Midwives Board.

November 8th, 1904.

#### INOPERABLE CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—I beg to say that the abdominal case noted by Dr. J. A. Shaw-Mackenzie, in his paper, "On the Treatment of Inoperable Cancer by Hypodermic Medication," in THE MEDICAL PRESS AND CIRCULAR, October 19th, has been under my care, and I can so far corroborate the results obtained with the hypodermic injections of Chian turpentine I have given.

I am, Sir, yours truly,

FRANK BOXALL.

Rudgwick.

#### CHLOROFORM ANÆSTHESIA.

To the Editor of the MEDICAL PRESS AND CIRCULAR.  
SIR.—In an editorial article, November 9th, headed "Chloroform Anæsthesia," you refer by name to me, and after mentioning that I have used the Vernon Harcourt chloroform inhaler with success in some hundred cases, you add "as far as we know, no details of them (the cases) have yet been made known, and it was more than hinted in the Oxford discussion that there were others in which he had not been so fortunate." Allow me to say it is quite untrue that any suggestive hint or more than hint was made publicly at the Oxford discussion in reference to cases of anæsthesia under chloroform conducted by me; had there been it would at once have been answered.

All my cases have been noted, and in no single case has death or any dangerous symptom due to chloroform arisen. Any hint or "more than hint" suggesting such death or dangerous symptom is devoid of all truth.

I am, Sir, yours truly,  
DUDLEY W. BUXTON.

London, W., November 14th.

### Literary Notes and Gossip.

MESSRS. LONGMANS, GREEN AND Co. will publish next month a "Text-book of Medical Practice," by various contributors, edited by Dr. William Bain. Apart from the practical character of the book, the special features are that the anatomy, histology, and physiology of each organ or system precede the description of the diseases, and that the various sections are contributed by general physicians and specialists.

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MESSRS. BAILLIÈRE, TINDALL, AND COX will publish next week, in their popular "University Series," the ninth edition of Dr. Macnaughton-Jones' "Manual of Diseases of Women." This book has met with a success almost phenomenal, and the new edition is announced to contain between six and seven hundred coloured and plain plates and other illustrations, the text being revised to date, and all the latest British, Continental and American methods in gynecology portrayed.

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AN important addition to the literature of Cities and of Civics has just been made by Messrs. Geddes and Co., of Edinburgh and Westminster, and the St. George's Press, Bourneville, by the issue, on the 10th inst., of "City Development, a Study of Parks, Gardens, and Culture Institutes; a Report to the Carnegie Dunfermline Trust," by Professor Patrick Geddes, at 21s. net. Professor Geddes has approached his task of designing the improvement of a city at once with local survey and with general ideas, and thus his book will be found to appeal to citizen and city improver, municipal councillor and official, architect and gardener, educational and social worker, &c., to antiquary and to Nature-lover also.

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THE term "fever" embraces so many illnesses, from mumps to typhus and yellow fever, that a book such as the "Manual of Fever Nursing," shortly to be issued by Messrs. Kegan Paul, of Dryden House, should prove useful. It is written by Professor Webb Wilcox, and deals exhaustively with fevers, their causes and symptoms, and their treatment in accordance with the present state of practice. The clinical charts and directions for nursing suitable for different cases should make this a valuable handbook for nurses.

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"LETTERS on Health and Happiness" is the title of a little work by John A. Bevan, M.D., Torquay. No one can say that at the present there is a lack of counsellors in regard to matters relating to personal and public hygiene, but although knowledge comes, wisdom lingers, and even though the path to heaven be paved with good intentions, happiness is by no means assured. Dr. Bevan, in these well-intentioned letters, tells us that his object is to remove suffering, to restore health and strength, to prevent irremediable organic disease, and to prolong the blessing of a cheerful mind in a healthy body to a genial longevity. There is much information unconventionally expressed in these unpretentious pages, and although we cannot endorse much of the pathology, we cordially admire the spirit which has prompted the publication of these life lasters.

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ANOTHER professional journal has been launched during the last few days by the energy of its publishers, Messrs. Baillière, Tindall, and Cox, entitled the

**Dental Surgeon.** Hitherto the dental section has been catered for by two or three monthlies, but, like all other professions, the dental has strongly expressed its desire for a more frequent medium of inter-communication, which has now been met. We have the first two weekly numbers before us, edited by Mr. Robert Manning, who will be assisted by a considerable number of dental surgeons, the majority of whom are attached to the dental schools and hospitals in the leading centres of the United Kingdom. These initial numbers are distinctly creditable, both to the editorial staff, and to the publishers, and if future issues can be maintained at such a high standard, no prophetic acumen is needed to foretell the chances of such a publication. Our new contemporary has our best wishes.

### Obituary.

ACHILLE VINTRAS, M.D. SCOTLAND, M.R.C.S. — ENGLAND.

THE news of the death of the senior physician of the French Hospital and Dispensary will be received with regret by a large circle of friends and acquaintances. After a long and busy life, Dr. Vintras died on the 9th inst., at Brighton, at the age of seventy-five. His medical education was conducted at St. Mary's Hospital, and in Paris. In 1858 he became M.R.C.S. of England, and the year after he took the degree of Doctor of Medicine of St. Andrews University. He was an Officer of the French Legion of Honour, and Physician to the French Embassy in London, as well as holding many other distinguished posts. His death, which took place in the French convalescent home he directed at Brighton, will be greatly felt by the French colony in London, in which he has been for so many years a prominent figure. Dr. Vintras' literary contributions were principally confined to books and papers on the Mineral Waters and Health Resorts of France, his other essays being two small pamphlets on "The Treatment of Diabetes" and "Animal Vaccination."

DONALD M'LEOD, M.D. GLASGOW.

WE regret to announce the death of Dr. Donald M'Leod, who has earned the title of father of the medical profession in Kilmarnock. He died at his residence on the 9th inst., aged 83. He had practised in the town for fully half a century, but retired about eighteen months ago. For a long period he was medical officer to the Parochial Board and Parish Council. He was a physician of exceptional skill. His medical education was conducted at Glasgow University, where he took the degree of M.D. in 1850.

DR. C. D. F. PHILLIPS.

WE regret to record the death, at 1 Hyde Park Square, London, on Sunday last, the 13th inst., of Dr. Charles Douglas Fergusson Phillips, late of Henrietta Street, Cavendish Square, W., at the age of 74. Dr. Phillips qualified in 1852, and was M.D. Aberdeen, LL.D. Aberd., LL.D. Edin., F.R.C.S. Ed., F.R.S. Ed., M.R.C.P. Lond., and Hon. Fellow of the Medico-Chirurgical College of Pennsylvania. He was at one time Lecturer on *Materia Medica* and Therapeutics at the Westminster Hospital, London, and subsequently Examiner in these subjects in the Universities of Edinburgh, Glasgow, and Aberdeen. He was the author of a well-known work on *Materia Medica*, the third edition of the first volume of which was published only a few months ago. He had retired from practice, and was the Chairman of the Universities of Glasgow and Aberdeen Liberal Unionists' Association. The immediate cause of death was the Stokes-Adams syndrome, and he was attended in his last illness by his old friend and colleague, Dr. Murrell.

### Medical News.

#### Medical Aid to Seamen.

IN response to a request made by the Missions to Seamen, Messrs. Burroughs Wellcome have given that Society a case of tabloid medicines, with a copy of their "Brief Medical Guide for Explorers, Missioners, etc.," to be used only in circumstances outside the reach of medical aid. They were given as outfit for the Bristol Channel Mission steamer *Eirene* in her visits to lightships and other vessels in the outer anchorages for use by the Roadstead Chaplain of the Missions to Seamen.

#### Entrance Scholarships: Westminster Hospital Medical School.

THE examinations for the entrance scholarships at this school have resulted as follows: Epsom Scholarship of 110 guineas, Mr. H. F. R. Davison; University Scholarship of 40 guineas, Mr. R. W. Ironside. Natural Science Scholarship of 60 guineas, Mr. H. S. Hingston; Governors' Scholarship of 40 guineas, Mr. W. R. Asplen; First Scholarship in Arts of 60 guineas, Mr. C. G. Richardson; Second Scholarship in Arts of 30 guineas, Mr. H. Evans; Science Scholarship of 40 guineas, Mr. A. O. Mitchell.

#### The New President of Queen's College, Cork.

THE more than enthusiastic reception which the newly-elected President of the Queen's College, Cork received on his arrival at his new sphere of duty should be a sufficient answer to those of our contemporaries who openly stated that his election was the result of a political job, and that the President would not be favourably received in Cork. Professor Windle was met on his arrival at the railway station by a procession of some three hundred students, who loudly cheered him. Mr. J. Horgan, a leading Cork citizen, introduced the more senior of the students to the President and presented Mrs. Windle with a bouquet of flowers. The following address of welcome was then read:—Address from the Students of the Queen's College, Cork, to Bertram C. A. Windle, Esq., F.R.S., D.Sc. F.S.A.

Dear Sir.—We, the students of the Queen's College, Cork, tender to you a thousand welcomes to our city. Your appointment to the high and honourable position of President of our College has given pleasure not only to us whose lives are spent within its halls, but also to great numbers of thinking Irish people, who are glad to recognise in you a worthy representative of the better system of government which is happily beginning to prevail in many spheres of national life. We recognise that you are a fellow-countryman by every claim that a man can urge to be called such. You have shown a deep interest in the language and glories of the ancient Gael, and we would suggest that here, in the heart of the great province of Munster, you will find scope for renewed efforts in the cause of intellectual and national regeneration. We are well aware of your brilliant literary attainments, and in these days, when too many people abandon themselves to the pursuit of a solitary subject and lose, in the fastnesses of the museum or the dissecting chamber, those qualities necessary for the civilised intercourse of life, we rejoice to meet with one who, as you, leaps the barriers of anatomy and wanders away to the sunnier regions of archaeological and Shakespearian research. We trust, then, that under your presidency Queen's College, Cork, may continue with ever-increasing vigour, the great work of professional education which it has so long carried out, and we again wish you welcome and prosperous days in this "Faire Citie" of the South.—Signed on behalf of the Students,

Faculty of Medicine—W. C. T. Robey, M. White, J. C. Hart, T. P. Sheedy, E. Forbes;

Faculty of Engineering—Arthur Ridge, Thomas J. Waters;

Faculty of Arts—D. L. Kelleher, David Horgan. After reaching the College quadrangle, the President made a short speech to the students, in the course of

which he testified to his pleasure at having returned to his native country. The proceedings then terminated amidst renewed cheering.

#### Catholic University Medical School.

*Medical and Scientific Society, Session 1904-5.*—The following officers have been elected for the ensuing session: President, Professor Antony Roche; Hon. Secs. and Treasurer, A. N. M'Loughlin, O'Connell O'Sullivan, J. B. Butler; Committee, Professor D. J. Coffey, Professor E. J. M'weeney, Dr. Dargan, Dr. M'Loughlin, Dr. Blayney, Dr. O. Farnan, F. J. Madden, R. Slattery, T. T. O'Farrell, W. R. O'Farrell, J. Elwood, W. P. Dunne. The inaugural meeting will take place at the Medical School, Cecilia Street, on Thursday, November 24th, when the President will deliver an address.

#### Diphtheria Outbreak in Ireland.

An epidemic of diphtheria has broken out in the Drumlish dispensary district, Co. Longford, and twenty-four deaths from the disease have occurred.

### PASS LISTS.

#### Queen's College, Galway.

The following scholarships and exhibitions have been awarded by the Council:—

*Faculty of Medicine.*—*Senior Scholarship in Anatomy and Physiology:* John L. Dunlop, B.A. Fourth Year: Scholarship, James J. A. Gannon; Exhibition, Joseph M. A. Costello. Third Year: Scholarships, John Hughes, Christopher F. X. O'Sullivan; Exhibitions, Joseph D. G. Burke, Richard G. C. M. Kinkead, John W. Garry. Second Year: Scholarships, Edward Dowling, Michael J. Mulligan; Exhibition, George Deery. First Year: Literary Division, Scholarships, Michael G. Devine; Exhibitions, Bartly Byrne, Michael G. O'Malley; Science Division Scholarships, Thomas G. Rothwell; Exhibitions, James A. Brown, Jame M. Riorth.

#### Trinity College, Dublin.

MICHAELMAS TERM, 1904.

*Previous Medical Examination.*—*The following passed in Anatomy and Institutes of Medicine:*—Henry J. Keane, Henry D. Woodroffe, Albert J. T. M'Creery, John C. Baker, Francis O'B. Kennedy equal; Langford V. Hunt and James G. G. Moloney, equal; Henry P. Hart, Herbert Allport.

*Physics and Chemistry:*—Arthur H. Laird, John Gray and Julian B. Jones, equal; William E. A. Moore, Wellesley R. Allen, Richard D. Fitzgerald, John H. Morton, equal; Cecil J. Grene, Henry R. Kenney, James D. K. Roche.

*Botany and Zoology:*—Henry de C. Dillon, Harold S. Sugars.

*Previous Dental Examination.*—*Anatomy and Institutes of Medicine:*—Charles R. Kidd, Arthur K. Macdonald.

*Materia Medica:*—Charles R. Kidd.

#### Royal College of Surgeons in Ireland.

The Carmichael Prize of £120 for the best essay "On the State of the Medical Profession in its Different Departments" has been awarded by the College to Dr. Michael Foster Reaner.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on the 2nd inst., with the following results:—

*Final Examination.*—Of eighty-four candidates entered, the following thirty-eight passed the examination, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—Joseph van Someren Taylor, China; Henry Lawrence Ludovici, Colombo; John Roddick Byers, Canada; Stuart Evans, Ottawa; William Murray, Middlesbrough; John Browne Grogan Mulligan, Belgium; James Francis O'Mahony, co. Cork; Ernest Temple Curran, Ontario; Thomas Cassels, Mangalore; James Patrick Barry, New Zealand; Geo. Galen Bartholomew, Scotland; Carel Theodorius Möller, South Africa; John Michael Moriarty, Ireland;

Samuel Mortimer Lyon, Ontario; James Ringland Lawther, co. Down; Damadar Babaji Mandhle, Bombay; Maneckji Pirozshah Kerrawalla, Bombay; Colin Garner, Preston; Lilian Mary Grandin, Jersey; James Harvie, Lesmahagow; John Pringle Tolmie, Inverness; Harvey McKay, Toronto; Alan Cunliffe Vidal, Eton; Ruston Nusserwanji Coorlawala, Satara; Robert Wilfrid Simpson, Glasgow; James Joseph Egan, Galway; Mohamed Ebrahim Sufi, Lucknow; Rowland Hill Harris, Maine, U.S.A.; Henry Bentley, Manchester; William Dick, co. Tyrone; John Douglas Staley, Youlgreave; Thomas Alexander Wiltshire Walker, Hyderabad; Edwin Herbert Freeze, Canada; Timothy Archdeacon, co. Cork; James William McEwan, U.S.A.; Walter Longley, Leeds; Kashibhai Vaghajibhai Amin, Ahmedabad; and John Black Moffatt, Airdrie; and ten passed in the division of medicine and therapeutics; three in surgery and surgical anatomy: six in midwifery, and six in medical jurisprudence.

#### Royal College of Physicians and Surgeons.

CANDIDATES have passed as undernoted:—

*Third Professional.*—*Passed in all subjects:* A. P. Barrett, M. D. Healy, C. W. O'Keefe, John Prendiville, C. H. Waddell, and Rupert Welply. *Completed examination:* L. A. Andrews, C. J. Bergin, T. S. Blackwell, John Burke, W. J. Connolly, R. F. O'T. Dickinson, T. A. Fisher, Cormac Gordon, J. J. Hogan, John M'Quillan, William Roche, William Sheahan, Edmund Smith, J. R. Talbot, N. R. Ussher, J. J. Vasquez, and G. F. Wright.

*Final Examination.*—*Passed in all subjects:* J. R. P. Allin. *Completed Examination:* Michael Ambrose, E. C. Byrne, H. A. Cecil, Selby Clare, F. X. Costello, H. B. Evans, P. E. Harrison, M. C. O. Hurly, E. C. Jennings, R. W. D. Leslie, M. J. Lochrin, V. H. MacSwiney, E. C. Mulligan, J. C. Murphy, T. J. O'Donnell, B. H. Peters, John Pratt, S. H. Robinson, A. J. Swanton, and Edmond Walsh.

*Supplemental Preliminary Examination, Autumn, 1904.*—Candidates have passed this Examination as undernoted:—*With honours:* O. W. J. Wynne. *Passed:* J. V. M. Byrne, C. P. Corbett, E. J. Curran, Thomas Duncan, L. M. Ewart, Charles Greer, Joseph Marmion, H. S. Meade, John Menton, Rodk. O'Connor, R. S. White, and W. H. Wray.

#### Conjoint Examinations in Ireland.

CANDIDATES have passed this examination as undernoted:—

*First Professional.*—*Passed in all subjects:* James J. Barry, A. H. T. Warnock. *Completed examinations:* Stephen J. Barry, J. Brereton-Barry, Thos. G. Brown, Noel M. Herbert, L. C. Johnston, H. G. M. Miles, K. A. P. R. Murray, Joseph McDonagh, D. S. MacDowell, Pierce Noonan, Martin C. O'Hara, Richard P. Power, F. Blood Smyth, and Bernard Wallace.

*Second Professional.*—*Passed with honours:* John Molyneux, J. F. Walsh, John McNamara, Patrick J. McKeveell, Charles J. B. Dunlop. *Passed in all subjects:* H. C. Burbidge, M. Beauchamp Dooley, R. de S. B. Herrick, A. A. Murray, Patrick J. Murray. *Completed Examination:* William Carroll, A. L. Clarke, James Joseph Clarke, James J. Corr, George A. Francis, Stanislaus A. Furlong, John Holmes, J. P. O'Kane, W. Roche O'Farrell, William A. Ryan, James V. Sage, G. B. Spencer, and Lionel D. Woods.

The Bishop of Durham has delivered judgment in the appeal by Miss Cadell, a lady doctor practising in London, against the decision of the warden of the University refusing to permit her to sit for the final examination in medicine at Durham. Dr. Cadell had previously failed in this examination and had in letters made allegations of favouritism and partiality against the examiners. The University authorities thereupon refused to permit her to sit again. She appealed to the Bishop, who is Visitor of the University. He decided that her letters were offensive and a breach of University discipline. He, therefore, upheld the warden's decision and dismissed the appeal.

## 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 void 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.

**H.S. (Crewkerne)**.—"Suet," properly speaking, is obtained from the abdominal fat of the sheep, purified by melting and straining. It is used for preparing mercurial ointment. It consists chiefly of stearine and differs in various points from beef suet.

### DEATH AT THE CARD TABLE.

WHILE playing at cards with his son-in-law, Simpson Jacobi eighty-one, a retired shipping agent, of Shepherd a Bush, suddenly dropped the cards and died. At the inquest last week it was stated that death was due to the rupture of an aneurysm in the aorta, caused probably by excitement. In former times this would infallibly have been alluded to as a visitation of Providence.

A **BIRMINGHAM STUDENT**.—The constancy and inconstancy of employment necessarily affects the prevailing rate of wages. Higher wages are required to keep a man employed only part of his time. That general rule, however, does not apply to the "part time" Medical Officer of Health, because his income is derived mainly from general practice. He can thus afford to take less than the average standard salary due to a public health post—and gives less in return.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 16th.

**ROYAL MICROSCOPICAL SOCIETY** (20 Hanover Square, W.).—8 p.m. Paper.—Mr. A. E. Conrady: Theories of Microscopic Vision. (A Vindication of the Abbe Theory.)

**ROYAL METEOROLOGICAL SOCIETY** (Institution of Civil Engineers, Great George Street, Westminster, S.W.).—7.30 p.m. Papers.—Lieutenant C. Boyds, R.N.:—Meteorological Observing in the Antarctic. Mr. F. J. Brodie: Decrease of Fog in London during Recent Years. Mr. E. L. Holmes: Hurricane in Fiji, Jan. 21st-22nd, 1904.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.). 4 p.m. Mr. L. Cheate: Clinique. (Surgical.) 5.15 p.m. Mr. F. C. Wallis: Injuries to and Diseases of Joints.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (North-Eastern Fever Hospital St. Ann's Road, N.).—2.30 p.m. Dr. H. Cuff: Demonstration on Fever.

**CENTRAL LONDON THROAT AND EAR HOSPITAL** (Gray's Inn Road W.C.).—5 p.m. Demonstration:—Mr. S. Low: Oro and Laryngopharynx.

THURSDAY, NOVEMBER 17th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. C. T. Williams: The Principles of Treatment of Pulmonary Tuberculosis.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. F. P. Weber: Climates and Health Resorts in the Treatment of Pulmonary Tuberculosis. (Post-Graduate Course.)

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Dr. Chappel: Clinical Medicine.

FRIDAY, NOVEMBER 18th.

**SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN** (11 Chandos Street, W.).—5.30 p.m. Cases will be shown by Dr. J. Taylor, Mr. J. H. Evans, Mr. D. Drew, Dr. J. P. Parkinson, Mr. S. Stephenson, and Dr. H. Campbell. Specimens will be shown by Dr. B. Rogers, Dr. J. M. Fortescue-Brickdale, Dr. G. Carpenter, Dr. S. Curl, and Mr. D. Drew.

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

MONDAY, NOVEMBER 21st.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital).—4.30 p.m. Lecture: Mr. Cantlie: Liver Abscess and its Treatment.

TUESDAY, NOVEMBER 22nd.

**THERAPEUTICAL SOCIETY** (Apothecaries Hall, E.C.).—4 p.m. Dr. G. Sharp on *Strychnos Toxicaria Benth* and other Paralyzers of the Motor Nerve Ending.

## Vacancies.

**County Asylum, Mickleover, Derby**.—Junior Assistant Medical Officer. Salary £120 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

**Leeds Union**.—Assistant Medical Officer. Salary £120 per annum, with board, washing, apartments, and attendance. Applications to James H. Ford, Clerk, Poor-law Offices, South Parade, Leeds.

**Manchester Corporation**.—Medical Officer. Salary £250 per annum. Applications to the Chairman of the Midwives Supervising Committee, Public Health Office, Town Hall, Manchester.

**Wakefield West Biding Asylum**.—Assistant Medical Officer. Salary £140 per annum, with apartments, board, washing and attendance. Applications to the Medical Director.

**University of Birmingham (Faculty of Medicine)**.—Professor of Anatomy. Salary £800 per annum. Applications to Geo. H. Morley, Secretary.

**Braconbridge Asylum, near Lincoln**.—Junior Assistant Medical Officer. Salary £125 per annum, with furnished apartments, &c. Applications to W. T. Page, Jun., Solicitor and Clerk to the Visiting Committee, 5 Bank Street, Lincoln.

**Bermondsey Parish**.—First Assistant Medical Officer. Salary £17 per annum, together with rations, washing, furnished apartments, and attendance. Applications to E. Pitts Fenton, Clerk, Guardians' offices, 283, Tooley Street, S.E.

**Macclesfield General Infirmary**.—Senior House Surgeon. Salary £100 per annum, with board and residence. Applications to the Chairman of the House Committee.

**Gloucester General Infirmary and Eye Institution**.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

**Manchester Royal Infirmary**.—Resident Surgical Officer. Salary £150 per annum, with board and residence. Applications to W. L. Saunderson, Superintendent and Secretary.

**Holloway Sanatorium Hospital for Insane** Virginia Water, Surrey. —Junior Assistant Medical Officer (Lady). Salary £150 per annum with board, lodging, washing, attendance, &c. Applications to Dr. W. D. Moore, Medical Superintendent.

**Leicester Infirmary**.—House Surgeon. Salary £100 per annum, with board, apartments, and washing. Applications to Harry Johnson, House Governor and Secretary, the Infirmary, Leicester.

**Monkstown Hospital**.—Resident Medical Officer. Salary £40 per annum. Applications to the Hon. Secretary. (See Advt.)

**County Mayo Infirmary**.—Assistant Surgeon, also to act as Compounder. Salary £109 per annum, with apartments, attendance, &c. Applications to Dr. M. O'Malley Knott, Resident Surgeon. (See Advt.)

## Appointments.

**BABST, C. T. U.**, L.R.C.P., L.R.C.S. Edin., Certifying Surgeon under the Factory Act for the Wallsend District of the county of Northumberland.

**BARNES, FRANK, M.B.**, B.S. Lond., F.R.C.S. Eng., Honorary Surgeon to the Royal Orthopedic and Spinal Hospital, Birmingham.

**DAVIS, WILLIAM HENRY, M.B.**, B.Ch. B.U.I., House Surgeon to the Royal Victoria Hospital Belfast.

**FORTUNE, JOHN, M.B.**, C.M. Edin., Third Assistant Medical Officer to the Devon County Asylum.

**GIFFORD, GEORGE T.**, M.D. Durh., M.R.C.S. Eng., Honorary Assistant Surgeon to the Blackburn and East Lancashire Infirmary.

**INGLIS, D.W.**, M.D. Glasg., Certifying Surgeon under the Factory Act for the Jarrold District of the county of Durham.

**LATHAM, W.**, L.R.C.P., F.I. M.R.C.S. Eng., Certifying Surgeon under the Factory Act for the London and North Western Railway Company's Works at Earlestown, in the Newton-le-Willows District of the county of Lancaster.

## Births.

**CLEVELAND**.—On Nov. 9th, at Norwich, the wife of A. J. Cleveland, M.D. Lond., M.B.C.P., of a daughter.

**DUNLOP**.—On Nov. 18th, at 38 Chester Street, Edinburgh, the wife James Crauford Dunlop, F.R.C.P. Edin., of a son.

**HENRY**.—On November 18th, at Debenham, Suffolk, the wife of Howard Henry, M.B., of a son.

**MALCOLM**.—On Nov. 11th, at 18 Portman Street, London, W., the wife of John D. Malcolm, F.R.C.S. Edin., of a son.

## Marriages.

**BLACKER—BOWEN**.—On Nov. 8th, at St. Mary's Church, Tormarton, Glos., George Francis Blacker, M.D., F.R.C.P., third son of Commissioner General Latham Blacker, to Shirley Elvina Bowen, second daughter of Rev. T. J. Bowen, Rector of Tormarton.

**BROWN-NORMANDY**.—On Nov. 12th at Bombay, Capt. Robt. Brown, M.D., R.A.M.C., of Lucknow, eldest son of Dr. Eos-Brown of Strood, Kent, to Pauline Mary Elvina, eldest daughter of Frank Normandy, of Sutton, Surrey.

**KILNER—FRATT**.—On Nov. 11th, at Colombo, John Newport Kilner, M.B. Lond., Adra, Indian Assistant Medical Officer of the Bengal Nagpur Railway, eldest son of Walter John Kilner M.B. M.R.C.P., Ladbroke Grove, to Mildred, only daughter of John Wyatt Fratt, M.R.C.S., L.R.C.P., Otley, late of Wivelscombe, Somerset.

## Deaths.

**PHILLIPS**.—On Nov. 18th, at his residence, 1, Hyde Park Square, London, Charles, Douglas Ferguson Phillips, M.D., LL.D. F.R.C.S., F.R.S.E., aged 74.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, NOVEMBER 23, 1904.

No. 21.

## Original Communications.

### CASES ILLUSTRATING THE MODERN SURGERY OF JOINTS.

By J. JACKSON CLARKE, M.B.Lond., F.R.C.S.,  
Surgeon to the North-West London and City Orthopaedic Hospitals.

**CASE I.—Internal Derangement of the Right Knee.**—A vigorous man, æt. 22, first consulted me on March 8th, 1904. His right knee first became troublesome seven years previously, after a sprain received in playing football. He was obliged to leave the field with his knee flexed. Swelling of the knee rapidly ensued. The knee was bandaged, and the patient was advised to walk. Gradual recovery followed. Since that time the trouble has recurred at intervals, an anæsthetic being occasionally required to overcome the fixed flexion at the joint. It is of interest to note that his father has a similar, but less pronounced trouble with one of his knees. As to the past treatment, he had worn a support consisting of lateral steel bars jointed at the knee, and provided with spring patellar trusses, but without any benefit. Shortly before his first visit to me, in landing from a steamer, patient's knee underwent a twist, and again became locked. An anæsthetic was administered, and the limb manipulated, but this time without success, the knee remaining bent, swollen, and painful. Patient was able to walk a little, the knee being kept stiff and slightly bent. On examination, there was a very marked pit, or sulcus, at the inner side of the knee—a characteristic sign of detachment of the internal semilunar fibro-cartilage. (See Fig. 1.) The joint was distended with fluid, which made the sulcus the more striking. I recommended arthrotomy and removal of the detached tissue.

**Operation.**—On March 12th I made a curved incision over the sulcus, and through this I opened the capsule of the joint as far back as the anterior border of the internal lateral ligament. After all bleeding had been stopped the synovial membrane was opened to the same extent as the capsule—it was thickened, its joint surface was granular and stained a brownish colour. Much synovial fluid, also stained brown from effusion of blood, escaped, and more was forced out by pressing on the joint. The displaced tissues were now visible, and they comprised not only the semilunar cartilage, but a fibrous band (part of the capsule) as thick as an index finger, which had been detached with it. This mass lay between the femoral condyles, only its anterior end being visible. This was grasped by Spencer Wells forceps close up to the anterior attachment, and cut through behind the forceps and its free

end grasped, and by drawing on this by a second pair of forceps and flexing the knee, I was able to remove the anterior two-thirds by means of curved scissors. Most of the tissue grasped by the anterior forceps was also removed. The joint now offered no resistance to extension. The remaining fluid was expressed, the synovial membrane and the capsule were closed by separate continuous silk stitches, and the skin by interrupted silkworm-gut; the joint was firmly bandaged, and an anterior malleable splint applied. Repair was uneventful, the temperature remained normal, and the superficial stitches were removed on the eighth day. After this the patient wore a flannel bandage, practising gentle passive movements. A slight impairment of flexion was present, but had disappeared by April 18th, on which date the fluid had all but disappeared from the joint, and the patient was allowed to walk as much as he felt inclined, only being debarred from running and other athletic exercises. On September 1st, all the fluid had disappeared, and the joint and limb were normal in strength and function.

**Remarks.**—This case is an example of the most severe of the various conditions that are grouped together under the heading of "Internal Derangement of the Knee-Joint." The internal meniscus formed only a minor portion of the mass of tissue that had been torn from the capsule. When the joint was opened, I found it impossible to draw the band to the inner side of the condyle, so I contented myself with cutting off as much as I could reach by passing the curved scissors as far as was safe between the condyles. In operating on these cases, as far as my experience goes, there is not much to choose between a curved transverse (Annandale's) incision and a vertical one. As a point in diagnosis, the presence of a marked sulcus is noteworthy—its deepest part was caused by the attachment of the anterior and detached band of tissue. The accident was predisposed to by a family tendency to looseness of the joints.

**CASE II.—Ankylosis of the Right Hip-joint.—Osteotomy of the Femur.**—Percy —, æt. 25, sent to me by Dr. Morley (Portsmouth) in January, 1904. A robust young man presenting fixed flexion (35°) and adduction of the right hip, and when standing marked lordosis. He had to wear a boot raised two inches to compensate for the apparent shortening, and he limped in walking. A skiagraph showed complete obliteration of the joint cavity without dislocation. The history given was that in 1884 patient was sent to the Alexandra Hospital for disease in the right hip. He remained there one year, extension being applied in bed. At the end of this time he was sent to Bournemouth for six months. During

1888-89 two abscesses formed in the hip, and were opened. The subsequent treatment, concluded in 1890, left patient free from pain, but with the limb fixed in its present position. At the patient's request I admitted him to the City Orthopædic Hospital for treatment of the deformity.

**Operation.**—After ascertaining that there was no movement at the joint by exerting strong leverage upon the thigh, I decided to perform a subtrochanteric osteotomy, removing a wedge of bone, with its base directed externally and posteriorly, and then to wire the fragments together. This done and the wound closed except at its lower angle, where a drain was inserted for twenty-four hours, the modified Thomas's hip-splint, with a foot-piece, previously prepared, was applied. The patient had no pain whatever, and repair was rapid, so that on July 1st (four weeks after operation) I was able to allow the patient to stand up to be photographed. (See Fig. 2.) On August 12th, he was allowed to walk without the splint, some stiffness in the knee, where there was some genu valgum from the previous abnormal direction of the limb, being patient's only complaint. Patient left the hospital on September 10th, 1904, walking comfortably with his boot, raised only half an inch, and when seen two months later he was free from most of the limp in his gait that was present before operation.

**Comment.**—Removal of a wedge of bone in this operation enables the fragments to be firmly coapted by a broad surface, and if the wedge does not comprise the whole width of the bone, it does not entail any shortening. Wiring of the fragments secures the patient against pain or delay of repair, owing to movement and shortening from over-riding of the fragments. The Thomas's hip-splint is far more efficient in preventing any flexion at the seat of operation, and far more comfortable and convenient for nursing than any other form of splint that I have used after this operation—subtrochanteric osteotomy or Cant's operation.

**CASE III.**—*Ankylosis of Many Joints following Acute Osteo-Arthritis.*—Isobella —, æt. 30, thin, very anæmic, perspires a great deal; sent to me at the City Orthopædic Hospital; and I sent her to the North-West London Hospital, where she was admitted on September 30th, 1903. Patient a helpless cripple, unable to stand, walk, or feed herself. Three years previously she was taken ill with what was diagnosed as "acute rheumatoid arthritis," which affected most of her joints; the following list indicates—

1. *Temporo-maxillary joints:* stiff, but not completely fixed, and improving.
2. *Spine:* stiffness and pain in the lower cervical and upper dorsal regions; improved under treatment.
3. *Shoulders:* slightly stiff, getting worse; some grating developed later.
4. *Elbows:* complete bony ankylosis, in rectangular position; muscles greatly wasted.
5. *Wrists and fingers:* joints swollen, stiff, painful, and deformed.
6. *Hip-joints:* apparently normal.
7. *Knees:* both flexed to a right angle, some thickening of synovial membrane, tenderness, much pain on passive movement, which is very limited.

8. *Ankles:* both swollen from superficial œdema, and probably also effusion into joints; both feet dropped into equinus position.

In this case I had the advantage of the help of my colleague, Dr. W. Knowsley Girdley, who undertook the supervision of a course of radiant heat baths, from which the patient derived much relief to the pain in the joints. The plan of surgical treatment that I formed was:—(1) by excision of the joint to free the movements of the right elbow; (2) to correct the flexion of the knees and the equinus deformity of the feet, and finally, if the patient desired it, to excise the left elbow. This plan was carried out with gratifying success. The right elbow was excised on October 1st, the ham-strings were divided by open incisions, and the tendines Achillis were elongated on November 17th. Then walking instruments designed by myself were adjusted, and the patient left the hospital on April 16th, 1904, able to walk about unassisted for the first time for over three years. Quite recently she came to me to ask to have the shoulder-joints operated upon. I found that the grating in them had increased, but I decided to wait before excising them, in order to watch whether any improvement occurs under a course of salicylate of soda and tartrate of iron. At the present time the range of active flexion-extension movement in the right elbow is as shown in Figs. 3 and 4. The power of supination and pronation is limited by the stiffness at the wrist. The muscular power in the arm is now good. The knees have become quite stiff in the straight position, but the ankles have regained an almost normal range of movement.

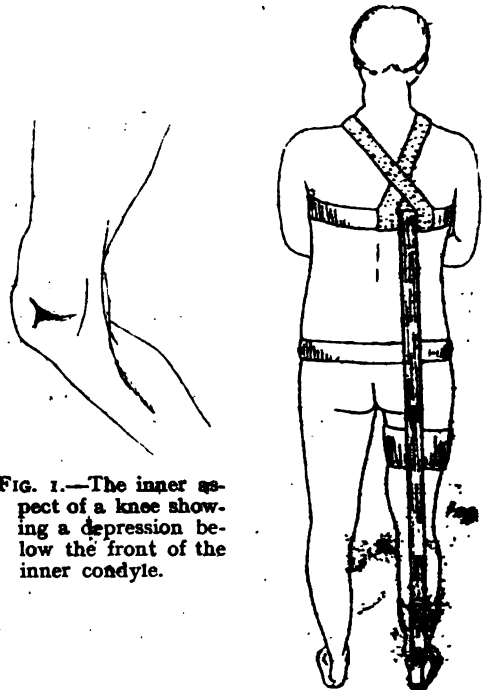


FIG. 1.—The inner aspect of a knee showing a depression below the front of the inner condyle.

FIG. 2.—A modified Thomas's hip-splint used after subtrochanteric osteotomy. (From a photograph.)

**Remarks.**—The case is one of many similar ones that have come to my notice during the last ten years, similar in all respects, save that this was the only one in which bony ankylosis was present.

and the only one in which the knees became rigid after operation. The ages of onset have varied from two (infantile rheumatoid arthritis) to forty-five years. All have begun more or less acutely, and in all many joints have been affected. All have been bedridden from deformity, being unable to walk on pain and sharp flexion at the knees and the equinus position of the feet. After correction of the deformities and the application of walking instruments, all have been enabled to walk, and that in an increasing degree, and



FIG. 3.—A patient after excision of the elbow, showing degree of voluntary flexion.



FIG. 4.—The same patient showing degree of voluntary extension.

with marked progressive amelioration of the joint symptoms and improvement of the general health.

The bone that was found joining the surfaces in both elbow-joints existed only at scattered points, fibrous adhesions being present elsewhere. The patient's temperature was normal throughout the time that she was in hospital.

### Paris Clinical Lectures.

## DIALYTIC TREATMENT OF AFFECTIONS OF THE STOMACH.

By PROFESSOR G. HAYEM.

[SPECIALLY REPORTED BY OUR PARIS CORRESPONDENT.]

"We have always in our service a certain number of patients suffering from gastric ulcer. This morning, I am going to speak to you of one of them whose history appears interesting, and at the same time I will give you some information on a method of treatment to which I have given the term "dialytic."

The man, of Bulgarian origin, æt. 30, is employed in an office. His father died at sixty-five of some malady unknown to us, while his mother still enjoys good health. No trace of nervous affections could be found in his family. About seven years ago the patient, who was at the time an engine-driver, fell from the engine flat on his face, with extended arms. Carried to his house, he complained of pain in his stomach. During ten days all food taken was rejected. The medical attendant treated him for ulcer of the stomach, and put him on hydric treatment for a week, with alimentary enemas, and afterwards allowed a glass of milk every two hours.

At the end of two months the patient was able to resume his work. Soon after, however, the gastric pains radiating to the back rendered the milk diet again necessary, and after some treatment by magnesia, bismuth, bicarbonate of soda, and codeine, the patient decided to enter the hospital.

Since we have had him under our care, he has not vomited either food or blood, but he suffers from his stomach about half an hour after meals. The pain is situated two fingers' breadth above the umbilicus and is increased by pressure. The patient complains of a burning sensation in the epigastrium and is always constipated. With the exception of the stomach, all the other organs are healthy, but the moral condition is deplorable. The patient is in a state of perpetual anxiety; he thinks that his malady is very grave and can support no noise. The analysis of the contents of the stomach showed hydrochloric acid in excess.

The above symptoms point to the existence of gastric ulcer, probably of traumatic origin. We submitted the patient to the usual treatment of round ulcer, which I have frequently had occasion to mention to you; it comprises one of the saline solutions which form part of the medication which I have called the dialytic treatment.

Having made a study of the principal drugs used in gastric affections as above, I have come to the conviction that all agents susceptible of irritating the mucous membrane of the intestine should be proscribed. Clinical experience has proved to me that the troubles of which dyspeptic patients complain are considerably improved by saline solutions, and these are the only remedies I use in the treatment of this group of affections.

I use the term dialytic medication because I believe that these solutions act partly, at least, by their physical qualities. These solutions are abundantly furnished under different forms by the natural mineral waters, but I seldom prescribe them because they are of a complex composition, and the effects on the organism have not been exactly defined, and I contend that just as good effects can be obtained from the artificial saline solutions. Their composition is more simple and presents the additional advantage of being capable of variation *ad infinitum*.

To acquire sufficient experience I reduced to a very small number the saline solutions I employ, and now know their effects, having prescribed them hundreds of times.

I limited myself to the study of four saline drugs: chloride of sodium, sulphate of soda, bicarbonate of soda and phosphate of soda.

Leaving aside for the moment all theoretical explanation, I am going to simply discuss the practical side of the question.

The solutions I studied are five in number, forming two categories—the solutions which act chiefly on the stomach and those which act on the intestine. I have numbered these solutions for the purpose of our lecture. The first category is represented by solutions of unequal composition.

No. 1 is as follows:—

Bicarbonate of soda, dr.  $\frac{1}{2}$ ;  
Sulphate of soda, dr. 1;  
Chloride of sodium, grs. 20;  
Water, one quart.

This solution can be employed in cases of gastritis with hyperpepsia; it is Carlsbad water simplified, and is used as prescribed at that watering-place.

In the morning, fasting, the patient takes ten ounces in repeated doses (a third part every twenty minutes) warmed to blood heat. This dose is increased by an ounce and a half each day until a pint has been reached. The cure should not exceed twenty-five days. The counter-indication to this solution is dilatation from want of tone of the stomach. The stomach which empties itself with difficulty should be otherwise treated.

Disease of the heart with tendency to oedema constitutes another counter-indication as well as cancer. I warn you against employing this solution with patients suffering from cancer. How often do we see each year cancer patients going to take a cure at Carlsbad and returning completely depressed?

The second solution is as follows:—

Chloride of sodium, dr. 1;  
Sulphate of soda, dr.  $\frac{1}{2}$ ;  
Water, one quart.

Employed generally cold at the dose of nine ounces taken at once, an hour before breakfast. The duration of the cure is six weeks.

The indications of this solution are very numerous. It can be used in slight hypopepsia with weak secretion; it answers to immediate indications by which we begin in the majority of cases.

The third solution:—

Chloride of sodium, dr. 1;  
Phosphate of soda, dr.  $\frac{1}{2}$ ;  
Water, one quart.

Is to be prescribed in cases of intense hypopepsia or apepsia, and is especially indicated in debilitated subjects.

Solution No. 4:—

Chloride of sodium dr.  $\frac{1}{2}$ ;  
Sulphate of soda, dr. 1;  
Water, one quart.

Is to be given warm in cases of large liver and atony of the intestine.

Solution No. 5:—

Chloride of sodium, dr.  $1\frac{1}{2}$ ;  
Sulphate of soda, dr.  $2\frac{1}{2}$ ;  
Water, one quart.

About twice the strength of No. 4, this solution is given in similar cases, half a glass fasting, and if well borne another half-glass a quarter of an hour after.

You have observed that all our solutions contain chloride of sodium, and before concluding, I wish to give you some information concerning the rôle played by salt in the treatment of gastric affections. Solutions containing chloride of sodium take a special place on account of the chloride constitution of the blood and gastric juice. Other things being equal, the more chloride of sodium furnished to the organism, the richer is the gastric secretion in chloride products. Thus the solution which I employ in the hypopeptic conditions contains a relatively large proportion of chloride of sodium (5-1000).

On the other hand, the chlorides should be diminished in hypopepsia, and this has been done empirically for a long time by prescribing the milk diet, especially in cases of ulcer. But the effects produced by this hypochloridation depend, in part at least, on the state of the mucous membrane of the stomach. The results are variable according to the nature of the case, whether it be one of mixed or parenchymatous gastritis. Where there is hyperpepsia in either of these affections, the milk diet tends at first to diminish the chlorides, but to obtain a permanent effect, it should be continued several months.

Widal and Javal having recently drawn attention to alimentation without salt in a case of Bright's disease, some doctors proposed the régime without salt for hyperpepsia, yet the same result could be obtained by giving large doses of bismuth, and a cure with the artificial solutions of Carlsbad, which cause the digestive troubles and dilatation to disappear if present.

## CONSTIPATION.

By TOM ROBINSON, M.D. St. And.

ANY medical man who is brought into contact with the public must be impressed with the number of individuals who are in the habit of taking aperient medicines. The habit is not confined to any age, class, or sex, but it certainly predominates among women. Some will swallow gallons of the mineral waters during the year; others will fly to the commoner aperients, such as Epsom salts or compound liquorice powder; many even drop into the pernicious habit of taking as frequently as every night a pill or compressed tabloid containing aloes. The habit is continued until the muscles of the bowels lean so long upon these crutches that they become weak, and the victims suffer from windy colic, internal rumblings, and often considerable irritation of the mucous membrane of the intestinal canal. The feebleness of the bowels may be so marked as to lead to complete stoppage.

In these few remarks on constipation it is my

intention to eliminate all those cases which are caused by any growth or other mechanical pressure. And I shall not either show cause why it is often of enormous advantage to administer what our predecessors so well called a "brisk purge."

Rightly or wrongly the ordinary citizen has a fixed and unalterable idea that for his well-being it is of absolute necessity that once every twenty-four hours the bowels must act. Our problem is how we are to produce this peace of mind without giving aperients. Our mode of procedure must be based upon the axiom that all effects have a cause. The cause of sluggish bowels are threefold:—

- (a) Insufficient and unwise diet.
- (b) The habitual taking of purgatives.
- (c) Deficiency in the muscular energy of the bowel.

In considering insufficient and unwise diet, we must remember that fæces only represent the waste products of the body; hence it follows that the diet must embrace a sufficient quantity of food which cannot be digested, and which, passing along the bowel way, stimulates that bowel to contraction, and by so doing urges on the fæcal wave. Brown bread and figs stand out as common examples. These are often not sufficient, and we must find other means.

Some time ago I was in the country and was watching some bullocks during the winter months, when the farmer's usually house them and give them linseed cake, and one could not help being impressed with the easy way in which these bullocks defæcated. This easy action of the bowels also takes place in grazing beasts. The thought struck me, why not give my costive patients linseed? one cannot give them grass. On returning to my work, I soon had an opportunity for putting my idea into practice, and ordered my first patient who was the victim of constipation to take one teaspoonful of flax seed floating in a goblet of cold water every morning before breakfast, and to repeat the remedy again in the forenoon until the bowels resumed a healthy function, impressing upon the patient the fact that time must elapse before the desired condition ensued. In three days the desired condition did ensue, and now, so far as I know, the sufferer is happy every morning owing to the fact that at a given hour fæcal relief is obtained.

There is one after-factor in the treatment, which is to insist on the patient drinking at least three pints of liquid every twenty-four hours. We must at the same time absolutely forbid the taking of any aperients. It is often asserted that some of our mineral waters, the pills and tabloids of commerce, do not cause constipation. This must be a fundamental error. Constipation follows the habitual use of any aperient medicine. It is a natural law, because every purgative acts by virtue of its power to increase the fluidity and quantity of the fæcal relief—*ergo*, after taking aperients these must be diminished.

Time and a healthy, regular, outdoor life will bring about the last condition, which, of course, is the final one. Give the thirty feet of intestinal tubing plenty of work to do and its muscular coat will become lusty.

## SOME ASPECTS OF METABOLISM—CHIEFLY CLINICAL. (a)

By WILLIAM CALWELL, M.A., M.D.,

President of the Ulster Medical Society; Physician to the Belfast Royal Victoria Hospital,

PART I.

GENTLEMEN,—An inevitable difficulty presents itself of the selection of a subject on which to address you. The embarrassment of riches in matters to be handled is great. There are the University question, medical education, medical politics, and medical ethics, the hospital system of the day, when philanthropists look askance upon the iniquity of demoralising children in the street by giving them a penny, but with complacency devote thousands in supplying to their parents what they are in many cases well able to procure for themselves, or would, had they not squandered their wages in miserable and unrestrained drunkenness. No one will deny that care should be taken of the flotsam and jetsam of our urban population, and a helping hand given to the industrious but unfortunate, whether from accident or disease, in life's struggle; but we cannot hide from ourselves that indiscriminate charity emasculates the energy, self-respect, and independence of the recipient, and tends to breed a rank and overgrown vegetation sadly needing the impartial weeding of Nature.

The relations between the various professions offer a rich mine to furnish material for introductory addresses. Since the Beck case, the law will probably be somewhat less bumptious, and will curb its mild jokes on doctors differing and mistaken diagnoses. However, we of medicine live in glass houses; and our decisions are occasionally of the same trustworthiness as that of the Beck case, even those that are delivered in our final courts of appeal. The value of much of our more abstruse and specialised scientific work has lately been debated. As an educational procedure it is invaluable; as a means of examination of a patient it is also of the greatest service; but microscopic sections and bacterial growths, blood films and cryoscopy are all liable to mistakes and fallacies, just as auscultation and percussion are, and the interpretation of results is all based upon experience. The laboratory is not a final court of appeal, but is simply a witness giving evidence, and that evidence may be most valuable, accurate and decisive, or useless, faulty, and of no moment. The responsibility rests with the practitioner; it cannot be delegated to others; it may be shared, or refused altogether; but it is the inalienable duty of the medical man in charge of a case to collect all the evidence he can, and come to a conclusion himself; and it is a pernicious doctrine to preach that a man who has never seen the patient should diagnose the disease.

Leaving, however, these subjects, as they furnish matter of daily debate and of correspondence in our papers, and as I have little or no especial experience or taste in them, I turn to a more personal choice. In looking over my own small contribution, which I had the honour of making to this or other medical gatherings, or to journals, I find there are two classes of disease which engaged attention somewhat more, perhaps, than others. For ten years I was medical attendant at the Throne Consumptive Hospital, and I believe I was the first in Ireland to advocate and to adopt the present method of treatment. I visited some of the German sanatoria and described my subsequent experiences on more than one occasion. But since this revolution of hyper-ventilation and hyper-alimentation but little new in principle has been developed. It would be worse than useless to reiterate the old discussions; the trial has taken place, the advocates have aired their eloquence, the judge has summed up, and now the jury, composed of thousands

(a) Opening Address delivered before the Ulster Medical Society, Session 1904-05.

of consumptives scattered over the realms of all civilised kingdoms, are debating in their own chests and tissues whether the hygienic treatment is a beneficent angel or a quack, a base fraud and deception. The deliberations of the jury are not yet approaching an end, and for the next ten or fifteen years they should be left in peace. Some new series of statistics or some paper embodying the results of experience are added from time to time. No final verdict can be given yet. My own opinion is unchanged. One may not approve of all the details, but the method is an immense advance to a higher, more logical, brighter and happier life, not only among the consumptive, but in every path of life.

In 1899, two years before the publication of Mayb Robson's "Diseases of the Stomach and their Surgical Treatment," I read a short paper at Portsmouth on organic adhesions of the stomach as a cause for some forms of dyspepsia, and recommended mechanical interference. Since then, experience has grown and earlier opinions have been modified. But it is now a recognised principle that cases of chronic dyspepsia showing signs of ulceration, past or present, of cicatrization and adhesions, should not be allowed to starve into a painful, miserable, and too-long-delayed death, but should take their courage in their hands and risk the great issue for the chance of formerly undreamt-of recovery. Here surgery has achieved one of its most signal victories. It is true that the description of the old English surgeon is not quite banished; some of the operations are still "terrible in the doing and melancholy in the event"; but when we consider the hopelessness of the case, and the large portion of success that attends interference, we must congratulate ourselves on the merits of the school of surgery in our midst, not merely in abdominal work, but in the general principles, *technique*, of our surgery as a whole. As part of this second point on which I have laid stress, both before my fellow medical men and in teaching at the bedside, I may mention the constant connection of chlorosis and gastric ulcer, so that it has become a fad with me—as all somewhat novel and strange convictions are politely termed by one's friends—that the so-called tea-dyspepsia of anæmic girls are really small, rapidly forming, and happily often rapidly healing gastric ulcers; and that such ulcers are a local manifestation of a constitutional affection. They are often overlooked, but at times prove their importance in an unmistakable manner and usurp the throne of the premier disease. I have, however, no new facts to put before you on either of these issues. Besides, like the consumptive problem, the principle has been affirmed; we require the experience of years to mould it, so that the finally developed procedure may pass into the accepted canons of our art.

I have been endeavouring to classify for my own edification diseases of the stomach other than cancer and ulcer, but have found the connections between pure gastric and gastro-intestinal-hepatic affection so close that it is nearly impossible to draw a line of demarcation. I thought, therefore, of abandoning a frontal attack, and approaching the stomach from the other or hepatic side before dealing further with gastric or intestinal derangements.

During both studies of phthisis and gastric troubles, if I may so dignify these very incomplete observations, the groundwork or constitution of a patient on which we, as professional artists, had to work was forced upon my attention not once or twice, but at every turn and move. However, of a man's inherited qualities the study is entrancing, but, as regards practical therapeutics, somewhat wanting in hope. We cannot treat a patient's grandfather, although the Chinese may ennoble him, and nothing less than the unremitting treatment, preventive and curative, of four grandparents and two parents could remove the vice of blood and tissue from some patients. The effect by his environment on the other hand, is all important, and the effect of environment on the problems of metabolism constantly recur in dealing with disease in the province of the physician. It is one personally I have

been drawn closely to latterly, and I propose to make a somewhat rapid survey of the subject from a clinical aspect.

Evolution does not give much help. Plants are able to form their protoplasm from the constituents of the atmosphere, or the inorganic matter of the earth. By the sun's rays and their own inherent vitality they build organic matter of high potential energy from CO<sub>2</sub>, ammonia, nitrates, and mineral salts. The earliest appear to be sugar and starch, and by synthesis fats and proteids follow. One need have little doubt that could the evolutionary chemist of biology fathom the secrets of comparative physiology he would be able to trace the various stages of growth in lines radiating from the most elementary organic molecule in various directions of vegetable and animal life; and in that radius, at the end of which is man, ending in some molecule more complicated than that of the proteid of hæmoglobin.

In mental disease, help is obtained by a study of comparative mental physiology, in which we may include not only the study of animal mind of various stages of evolution, but also the growth of the child's mind with various stages of development. I have no doubt also that most interesting facts, important in the light they would throw on the etiology and treatment, will be discovered in metabolism. At present, however, such few details as I have been able to glean are not of sufficient importance to warrant me in detaining you longer than simply throwing out the suggestion. Reversion to ancestral types may be present, but so far its study is not of practical importance. The same may be said of child development.

In order to refresh our minds on some points of elementary physiology, I shall very briefly run over the accepted dicta of the changes which food undergoes after the action of the digestive juices has been exercised upon them.

Of proteid matter, the peptone formed in the alimentary canal is converted by the agency of the columnar epithelial cells of the mucous membrane of the intestine, back again to some more ordinary form of serum and globulin albumen; for no trace of peptone is found in the portal vein, although serum and globulin albumen is found in excess during a proteid meal. Injection of small quantities of peptone into the portal vein gives rise to peptonuria.

In the liver, no doubt, this albumen undergoes some further change, possibly some of it is converted into glycogen, but physiologists are rather in a fog in this region, and the intricacy of the subject is such that the most careful investigations and experiments fail to allow more than probable surmises. It then circulates through the body in solution in the serum; some small portion is assimilated by the fixed and floating cells and tissues, but the great mass of absorbed albumen remains in solution, and seems to act as a source of energy without being taken up into the tissues and organised. The exact subsequent changes form a subject of conjecture, or perhaps of logical inference, and are as mysterious as the movements of the Japanese army in Manchuria. It were too great a prerogative even for the presidential chair to inflict upon you a tithe of the names assigned to analogous changes in the test tube; finally, however, we meet with urea at the end of these long subcuticular wanderings, most probably formed in the liver and excreted by the kidneys.

Of the carbohydrates, the starches or poly-saccharides, and the cane-sugars or di-saccharides, are reduced by the saliva and pancreatic secretions to a monosaccharide such as dextrose. In the columnar epithelial cells of the villi, some change comes over this dextrose, as the carbohydrate found in the portal vein has a lower cupric oxide reducing power than dextrose. In the liver a return to the poly-saccharides is found in glycogen. What happens next is a matter of dispute. Pavy says sugar does not and should not reach the general circulation; others say that the glycogen is slowly given off as some form of sugar, which is used up in the fixed cells and in the lymph circulation, and disappears as water and carbonic di-oxide.



Fats are split in the intestine into fatty acids and glycerine. The former are reconverted into neutral fats by the columnar epithelial cells of the intestinal mucosa; and these fats are oxidised in the circulation into  $\text{CO}_2$  and  $\text{H}_2\text{O}$ .

The principles of the complicated chemical changes are not difficult to understand. On the one hand, by the agency of ferment the larger molecules of both proteid and carbohydrate are split up into smaller; this process is accompanied by hydration; there is a conversion of a high potential energy into a lower; but the molecule can now be absorbed. The process is exemplified in albumen and peptone, starch and dextrose, perhaps glycogen and dextrose, where the ferment is an internal secretion of the liver. On the other hand, by the agency of living protoplasmic matter, dehydration takes place, there is a combination of molecules, a formation of a molecule of higher potential energy, a synthesis of living matter, an absorption into the living protoplasm of a cell. As examples of this synthesis, we may adduce the formation of fat from a carbohydrate, or of the complex conjugated proteid as nuclein from simple proteid, fat, and carbohydrate. In the exercise of functions these complex compounds are broken, and this disintegration is mostly a question of oxidation. It is impossible to assign many of these substances to their exact place in the circuit of metabolism. Pavy assigns a great importance to the protoplasmic agency by the intestinal villi in the conversion of a dextrose into a high carbohydrate, so that no sugar should reach the blood circulation. In these cells he says there is a transformation of the sugar into fat, a synthesis into proteid and a transmutation into glycogen. We can easily understand how these delicate and complicated processes may be thrown out of gear.

(To be concluded.)

### Clinical Records.

#### A CASE OF OVARIAN DISEASE ASSOCIATED WITH UTERINE FIBROIDS. (a)

By BEDFORD FENWICK, M.D.,

Physician to the Hospital for Women, Soho Square.

THE specimen which I now show was taken from a patient, æt. 44, and unmarried, who was sent to me by Dr. Richmond, of Wimbledon. Ten years ago, she was told by a well-known obstetric physician that she had a fibroid tumour, but it would disappear at the change of life. It almost seems too much to hope that this antediluvian superstition will ever be decently buried, because one is constantly meeting with it in the case of patients with uterine fibroids who have passed through years of needless suffering and danger whilst waiting for a menopausal millennium. For the past six months, the patient has suffered from increasing pain in the abdomen, especially on the right side, and from increasing loss of flesh and strength. I performed abdominal section on October 24th, and had some difficulty in lifting up the mass as it was completely moulded into the shape of the pelvis. It was also exercising considerable pressure on, and causing some displacement of, the left side of the bladder. I performed hysterectomy in the usual manner, and as both ovaries were grossly diseased, removed them with the tumour. I then observed that the left ureter was greatly dilated, being about three times its normal calibre, evidently due to the effect of compression on the base of the bladder by the tumour. I had predicted this condition before operation, and had the urine measured carefully for a week previously, the average amount being only 35 oz. a day. Directly after the tumour was removed, the bladder rapidly filled, proving that there must have been a considerable collection of urine in the ureter and calyx of the left kidney, and after the operation the average amount of urine per diem rose at once to 55 oz. I feel confident that sufficient stress is not laid upon the danger to the

kidney caused by pressure on the ureter by fibroids of the uterus. Indeed, I regard this as one of the most serious and insidious complications to which these patients are liable. I desire to call special attention to the gross disease in both the ovaries attached to the tumour. The left ovary was converted into a blood cyst containing 8 oz. or 9 oz. of black blood. The right ovary contained about 4 oz. of congealed blood, about half its cavity being filled with a dense nodular growth, which has thinned the capsule at one part to a thickness of only one-tenth of an inch. The growth cut like scirrhous, and I am indebted to Dr. Aarons for the sections which are shown to-night, and which prove that the growth is a fibro-adenoma. In the next place I wish to call attention to the remarkable size of the ovarian arteries, which are four or five times their normal calibre. Dr. Aarons has kindly also made sections of these, and it will be observed that the middle coat of the artery is greatly hypertrophied. It will be within the memory of the Society that a distinguished Fellow, at a meeting some two years ago, showed a number of microscopic sections proving that the uterine arteries are greatly thickened in cases of fibroid disease of the uterus, and that he expressed his belief that this condition was the cause of the fibroid change. I then, and have since, ventured to point out that there is reason to believe that the increased hypertrophy of the uterine arteries is the consequence and not the cause of the fibroid change, and precisely resembles the hypertrophy of the muscle of the heart or of other arteries in the body where the circulation is called upon to overcome an increased difficulty or obstruction to the blood stream. And this case, and others which I have shown, in which the similar hypertrophy of the ovarian arteries occurs, goes further to prove my argument. But there is a practical point to which I have also drawn attention, and which this case strongly supports: that whenever we have fibroid thickening to any marked degree at the fundus of the uterus—that is to say, where the ovarian arteries enter the uterine tissue—then, and then only, will there be much obstruction to the flow through the ovarian vessels; then, and then only, do we find hypertrophy of the muscular coat of the ovarian artery; and then, and I am inclined to believe then only, do we find ovarian disease associated with the presence of the uterine growth. I would venture to emphasise these facts, because they have assisted me much in practice in this way: that when I find the fundus fairly free from fibroid growths I always leave the ovaries with an easy conscience, but when there are fibroids on one or both sides of the fundus, and considerable enlargement of the ovarian artery, I have always found sufficient disease in one or both ovaries to make it evidently advisable that they should be removed.

### British Health Resorts.

[BY OUR SPECIAL MEDICAL COMMISSIONER.]  
XVII.—PENZANCE.

CORNWALL has been described as the foot of England, the Lizard the heel, and the Land's End the toe. Towards the western portion of the arch lies Mount's Bay, and on it Penzance, which for long has won distinction as a most desirable winter resort for invalids, and a charming holiday centre in spring and during early summer. It is the metropolis of the western part of the Delectable Duchy, and forms an admirable residence for cases which require to live an open-air life during winter days, and yet are reluctant to leave the shores of the homeland.

The town is situated on the side of a declivity on the north-west shore of Mount's Bay. It is sheltered and yet lies open to the exposure of the bay, and while affording the comforts of a land residence, provides the advantages of a marine climate. Penzance records show that it enjoys the highest mean annual temperature of any British station on the Royal Meteorological Society's list. There is almost complete absence of extremes of temperature. The degree of humidity is

(a) Read at a meeting of the British Gynecological Society, November 16th, 1904.

comparatively low, and much sunshine prevails. During the six months comprised in the first and last quarters of the year it holds the record for warmth in the British Isles.

Snow is seldom seen, and severe frosts are rare. Penzance has been well characterised as "A Paradise for invalids." (a) The climatological report of Mr. C. H. Benn, the Borough Meteorologist, for 1903 (b) affords the following data:—"The mean temperature for the year was 52.41° F. The mean temperature for the winter months was 48.31° F. The winter mean range was 7.37°. The total sunshine is recorded as being 1,752 hours 25 minutes, a daily average of 4 hours 48 minutes and 2 seconds. The mean humidity is returned as 79 per cent., and the rainfall last year, which, of course, was unusually heavy, was 51.11 inches.

Penzance may well be selected as a good winter home for invalid and delicate cases who need outdoor life, a marine climate, and are interested in artistic influences. Newlyn, which is now practically a suburb of Penzance, has given its name to a renowned school of artists.

Patients, the subjects of chronic respiratory affections, find much that is congenial and attractive in this western seaside station. Many tuberculous cases here weather the winter well. Renal cases are also said to gain benefit. There is difference of opinion as to the value of the place in the management of asthma. Some cases of anæmia, and not a few cutaneous disorders, reap no benefit. For the convalescent and those who are to be considered vigorous invalids, the neighbourhood of Penzance can offer much that is peculiarly attractive.

The Isles of Scilly, which lie off the Cornish coast in the Atlantic, if it were not for the difficulty of reaching them, might form a veritable marine sanatorium. (c) Penzance is 321 miles distant from Paddington, but the enterprise of the Great Western Railway has rendered the journey easy, and the invalid can now travel in comparative luxury in seven hours.

## Transactions of Societies.

### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD NOVEMBER 10TH, 1904.

PROFESSOR JOHN W. TAYLOR, M.D., F.R.C.S., President, in the Chair.

#### EXHIBITS.

DR. MACNAUGHTON-JONES read the pathological reports on two cases of embedded adnexal tumours, which had been completely hidden by perimetritic exudation, and, later, exhibited with the epididymal sections of the tube illustrative of desquamative salpingitis. He raised the question of the necessity of hysterectomy if the uterus were not materially affected.

DR. R. H. HODGSON asked whether he correctly understood Dr. Macnaughton-Jones to attribute all the pain in salpingo-oöphoritis to peritonitis. Surely pain in an ovary or tube did not necessarily imply the presence of any peritonitis.

DR. HEYWOOD SMITH said that in deciding as to the removal of the uterus in ovarian disease one had to consider the age of the patient and whether she was, or was not, married. In his experience, the removal of the ovaries alone did not interfere with sexual appetite, which, when the uterus was also taken away, was very much deteriorated.

The PRESIDENT concurred with Dr. Macnaughton-Jones that it was, as a rule, an advantage to retain a uterus that was comparatively healthy; at the same time, even in abdominal operations, he found

himself more and more inclined to begin by curetting the uterus if he had any reason to think there was any endometritis.

DR. MACNAUGHTON-JONES, in reply, said that he had expressed no opinion in regard to the pain; Dr. Cuthbert Lockyer's report did, however, refer to the considerable influence which contractions of the hypertrophied muscular tissue of the so-called uterine platysma had on the clinical aspect of such cases. He had been recently informed by a patient from whom he had removed both ovaries, and on a subsequent occasion the uterus also, that her sexual appetite had not been in the least affected.

#### DR. BEDFORD FENWICK read notes on a case of OVARIAN DISEASE ASSOCIATED WITH UTERINE FIBROIDS,

which will be found under the heading "Clinical Records," upon page 541, and exhibited specimens.

The PRESIDENT said that he had occasionally, but only occasionally, found large blood cysts of the ovary in association with myoma of the uterus, in one instance as large as an ordinary water bottle, and in another as large in diameter as an adult's arm, and containing a quantity of black blood. In the cases he could call to mind the tubes had been quite free, and it did not seem that such cysts could be directly connected with menstruation, or with regurgitation of blood from the tubes. The pathogenesis of these cysts was very obscure, and he would be glad to hear if Dr. Bedford Fenwick had formulated, or knew of, any theory about the matter.

MR. CHRISTOPHER MARTIN said that, in his opinion, the most urgent of all indications for operative interference in fibroids was pelvic pressure, especially pressure upon the bladder and ureters. But pressure on the ureter in many cases added enormously to the risk of the operation, especially when the tumour was very adherent in the pelvis. In removing such a tumour not long ago (a fibroid embedded in the pelvis) he found one and a half inch of the ureter lying in a groove at the side of the mass removed. He performed nephrectomy on the corresponding side, but the patient died the next day from shock. In regard to Dr. Fenwick's theory of the causation of ovarian disease by pressure of a fibroid on the ovarian artery, that would not, he thought, justify the removal of an ovary apparently healthy; it was reasonable to suppose that when the tumour, and the pressure, were removed the circulation in the ovary would become normal again. Except for gross disease, it was better not to remove an ovary.

DR. FENWICK, in reply to the President's question, said that he had looked up the text-books on this very point some two or three years ago, and had been unable to find any explanation given, and in several no mention was made of the ovarian changes in fibroid disease of the uterus. The theory he had ventured to advance at this Society was, of course, only a theory, and nothing more; but it seemed to him to be not only plausible, but sufficient to explain the pathology. Increased power in the ovarian artery, combined with increased difficulty in the ovarian circulation at the uterine fundus, must inevitably mean a constant hyper-congestion of the intervening tissues, that is to say, in the ovary itself; and the effect of such congestion must be not only the production of inflammatory changes, but, in the case of such an organ as the ovary, a greater likelihood of cystic degeneration; and, given the formation of a cyst, the greater probability of rupture of a vessel, or of exudation of serum into the cavity, of rapid increase in the cystic area; or, in other words, of the production of the very condition shown in the specimen he had just brought before the Society, and he would point out that even if there was no rupture of a blood-vessel, the vascular changes would still explain the production of other forms of degeneration which are known to be associated with ovarian disease.

DR. HEYWOOD SMITH showed a uterus containing numerous fibroid tumours, one in process of sloughing; the right ovary was converted into a large blood

(a) Consult "A Pictorial and Descriptive Guide to Penzance," published by Ward Lock and Co.

(b) The Annual Report of the Medical Officer of Health (Dr. E. Davey Baines) to the Penzance Urban District Council, 1903.

(c) See "Lyonese: a Handbook for the Isles of Scilly" by J. C. Tonkin and Prescott Row. Published by the Homeland Association.

cyst, the left, though slightly enlarged, had not been removed, as the patient was young. An interesting point in the case was that the patient's temperature had been persistently subnormal, and that, in spite of the sloughing tumour, there had been no symptom to suggest suppuration.

Dr. HEYWOOD SMITH also showed, for Dr. Alexander Duke, a device for the removal of wet wool from a Playfair's probe, often in some hands a difficult proceeding. It consists of a little metal frame with a slot wider at one end. The probe is passed through the wide end, and on being pushed towards the narrower part, the wool is then easily slipped off.

Dr. BEDFORD FENWICK pointed out that in Dr. Heywood Smith's specimen the ovarian artery was greatly hypertrophied, being at the point where it was divided nearly double the normal size.

The PRESIDENT said that in connection with the interesting specimen shown by Dr. Macnaughton-Jones at their last meeting they had to discuss the condition known as hæmorrhagic endometritis.

Dr. MACNAUGHTON-JONES said he had brought the specimen again, but had little to add to his remarks at the last meeting. Cases of glandular endometritis attended with persistently recurrent hæmorrhage might pass into what was practically a form of pernicious anæmia, in which the condition of the woman was almost as bad as if she were suffering from malignant disease, and if bleeding recurred there was no hope but removal of the uterus.

Mr. CHARLES RYALL said that some years ago he had shown to the Society two specimens removed by hysterectomy, and his treatment met with a good deal of adverse criticism at the time, but in the condition described by Dr. Macnaughton-Jones, extensive hyperplasia of the endometrium with increase of the muscular and fibrous tissue, and general thickening of the uterine wall and some endarteritis, the curette, though repeatedly resorted to, seldom gave relief, indeed, generally made things worse; and for obstinately recurring hæmorrhage in such cases, removal of the uterus was the best treatment.

Dr. J. J. MACAN reminded the Fellows that the term "hæmorrhagic endometritis" was originally applied by Slaviansky some fifteen years ago to cases of profuse uterine hæmorrhage associated with inflammation, affecting chiefly the glandular elements of the endometrium, during an epidemic of cholera. The term, as Veit mentions, has been also applied to uterine hæmorrhages occurring during the course of the exanthemata. A report of one such case will be found in the number of the Society's journal now in the press.

Dr. MACNAUGHTON-JONES, in reply, said that he could understand the term hæmorrhagic endometritis being used in connection with the exanthemata, for during eleven years' work in a large fever hospital he had seen many cases of hæmorrhage from the uterus, but he attributed that hæmorrhage to a change in the blood rather than to any affection of the uterus. The condition he had brought under the notice of the Society was generally the result of long pathological change, and the question was, not so much the cause of the hæmorrhage, as the passing of some of these cases of glandular hypertrophy and desquamation into a state approaching malign adenoma.

Discussion on Mr. Christopher Martin's paper on the TREATMENT OF INTRACTABLE PROLAPSE BY EXTIRPATION OF THE UTERUS AND VAGINA.

(Vide ante MEDICAL PRESS AND CIRCULAR, October 26th, 1904. Page 429.)

Dr. J. A. MANSSELL MOULLIN said Mr. Martin had brought before the Society a new operation for the treatment of this distressing condition. Mr. Martin recognised the futility, or, at any rate, the temporary nature of the benefit to be derived from the many operations hitherto devised for the correction of prolapse. The operation now proposed did not rest on the cutting away and puncturing of tegumentary structures, but on a more solid and scientific basis, namely the union and reconstruction of the fascia

to form a pelvic floor resembling that of the male pelvis. It was well known that to repair a hernia occurring in the cicatrix of an abdominal incision it was essential to expose and unite the cut edge of the transversalis fascia. If this was done effectually, a good result was certain, otherwise the operation was in vain. Mr. Martin tells us that the pelvic fascia, which splits to enclose the upper portion of the vagina, does not itself become prolapsed, but that the uterus and vagina are prolapsed and stretched away from it. When these latter are removed, the cut margin of the fascia can be readily distinguished and united with sutures to the opposite side, thus obliterating the opening through which the vagina passes, and forming a continuous pelvic floor. Mr. Martin does not conceal the fact that the operation is a formidable one, and attended by many risks. An improved technique may possibly enable us to add it to our remedies for use in severe cases.

Dr. R. H. HODGSON, after complimenting Mr. Martin on the frank way in which he had given the details of his cases, said that it was noticeable that the fever and suppuration which in three cases did not occur till after ten days, in the fourth appeared on the second day after the operation. It seemed, therefore, probable that this fourth case was one of infection at the time of operation; the others, due to some change in blood-clots formed in the wound. The great tendency of blood-clots in the pelvis to undergo decomposition might, he suggested, be due to their proximity to the rectum, and to the difference between the coverings of the intestine outside and within the abdominal cavity. He had himself suggested some years ago that prolapse might be remedied, or prevented, by amputating the uterus at the internal os, drawing down the free edges of the broad ligaments through the cervix, and so making all the parts taut. This would save the vagina, which it was desirable to do, even in a woman getting on in years.

Dr. BEDFORD FENWICK said that he considered the Society owed a debt of gratitude to Mr. Martin for the excellent paper he had brought before them, and personally he much admired the skill and courage displayed in the operation Mr. Martin had described, because, to anyone who was constantly accustomed to operate on the abdomen or vagina, it needed no words to explain the difficulties of the operation in question. There were one or two matters which had particularly struck him in Mr. Martin's description. In the first place, he could not understand the special advantage of removing the mucous membrane from the anterior wall of the vagina, but as Mr. Martin did it, it seemed to him to explain all the suppuration to which Mr. Martin referred; for example, he apparently left an entirely raw surface in the canal, which was closed by granulation, which involved the formation of pus. If the lower part of the canal closed first, as it most probably would do, then the pus must collect at the top of the canal, and of course the septic conditions to which Mr. Martin referred naturally followed. Mr. Martin, indeed, seemed to have realised this, because he in each case passed a pair of forceps along the canal, liberated the accumulated pus, and the patient at once recovered. If he (Dr. Fenwick) were going to perform this operation, he would certainly feel inclined to modify it, therefore, to the extent of leaving the mucous membrane on the anterior wall untouched, and thus saving what everyone would know to be the most difficult part of the operation. Then by stitching its edges together one could reduce the canal to the diameter of an ordinary pencil, and in the great majority of severe cases he could not but think that colporrhaphy to this extent would be sufficient to entirely cure the patient. Moreover, it would leave no suppurating surface, it would not interfere with the relations of the uterus and ovaries, but it would to all intents and purposes close the canal into and through which prolapse of the rectum or bladder could occur. Then, again, in Mr. Martin's operation he could not but think that there must be a great practical difficulty sometimes in finding the

pelvic fascia, and when it had been found in drawing it together sufficiently to close the base of the pelvis, which, as he understood the procedure, was the scientific principle on which Mr. Martin's operation was founded, and which, as a principle, both anatomical and pathological, he cordially accepted. Nature had created a wide separation between the fascia, and in his experience it was in some cases not easily found. He, therefore, was inclined to believe that cases might occur in which the edge of the fascia could not be defined, and others in which it would not be possible, by any permissible traction, to draw the edges of the fascia into a sufficiently accurate position to obtain firm union.

Dr. MACNAUGHTON-JONES commented on the fact that only on the rarest occasions was such an operation called for, as acknowledged by Mr. Martin himself. He (Dr. Macnaughton-Jones) had on three occasions removed the uterus and then performed free colporrhaphy. In these cases the bladder and bowel were down in the proident sac. They were all permanently relieved. It was rarely indeed where even this step was necessary. A Schroeder's operation, consisting of colporrhaphy and high amputation of the cervix, with a deep perineorrhaphy, was sufficient in the majority of instances, combined, if need be, with a ventrofixation, or better still, an Alexander-Adams operation. So far back as 1889 Professor A. Martin (now of Greifswald) had performed complete extirpation of the vagina and uterus for both cancer and proidentia. The operation differed in the two instances. In 2,000 cases of proidentia, up to the end of 1903, Professor Martin had performed total extirpation nineteen times. He removed the adnexa also. In commencing all such operations a good deal of bleeding might be avoided by early ligation of the vaginal branches on the uterine trunks. The rarity of the operation did not detract from the boldness or ingenuity of the procedure.

Dr. JERVOIS AARONS said that he was much struck with the ingenuity of Mr. Martin's operation. He had, since the paper was read, seen a case of prolapse which recurred after hysteropexy, perineorrhaphy and anterior and posterior colporrhaphy, and for such a case, especially in a woman past the menopause, the method promised relief otherwise unattainable.

The PRESIDENT said: I have watched with very great interest the work of my colleague, Mr. Christopher Martin, on the extirpation of the uterus and vagina for the treatment of severe prolapse, and can, from my own observation, confirm a good deal of what he has told us. But while I can and do most heartily admire the use of thought and skill which are united in the performance of this long and difficult operation (for there is one part at least in its performance when, if I remember rightly, as the uterus is turned downwards and backwards, all ordinary relations are more or less reversed, and every attention and care is necessary to understand as well as to perform the work), I am not fully satisfied after all is completed that the best has been done for the patient. The loss of the vagina is a serious loss, and what Mr. Martin regards, and rightly regards, as the essential part of the operation—the rebuilding up of the stretched pelvic fascia—can be obtained in another way, I think, without the loss of the whole vagina. If, after starting to repair a perineum by Mr. Tait's method of flap-splitting, the upper flap of the posterior vaginal wall be grasped by the left thumb and forefinger and the scissors dissection be carried up higher and higher between the rectum and vagina, a plane is finally reached where there is only the firmest union between the vagina and rectum, and the finger can bluntly separate the two right up to the cervix if necessary. Now, if this be done, the separation being not only carried high enough but extended (by dissection) freely on both sides, and the long, triangular flap of vaginal membrane thus produced be fully excised, you find a condition exactly similar to that produced by Mr. Martin in its free exposure of the pelvic or recto-vesical fascia. Some of this has been already removed by the removal of the vaginal

floor above it, and you can see the edge of the fascia as a distinct structure on each side, a divided membrane, which can be still further excised or united at once, at the discretion of the operator. It is the repair and firm suture of this, confining the rectum backwards, that is the essential in the cure of every rectocele, but I question whether it is of much use in the prevention of a cystocele. The accompanying cystocele in cases of bad protrusion needs separate treatment. The usual operation I have done for some years in cases of severe prolapse is, first, a repair of the cystocele by anterior colporrhaphy, with a buried tier-suture of the base of the bladder, so as permanently to contract its capacity and cure all anterior bulging. The suture is a continuous one of the finest silk, carried from urethral orifice to cervix, back again from cervix to urethra, and still back again from urethral orifice to cervix, enfolding more and more of the dilated and redundant bladder, until the base of the bladder and anterior wall of the vagina are perfectly taut and firm. Here the fascia is sometimes recognisable, more often it is not; but the remains of it are taken up with the floor of the bladder in the silk suture. This suture is buried. A separate running silk suture unites the vaginal wound over this. The uterus is then fully replaced, another posterior dissection between the rectum and bladder carried out as I have described. As much of the posterior and lateral vaginal wall as is considered advisable is then removed through nearly the whole length of the vagina. Deep sutures of silkworm-gut are passed to bring the raw surfaces into close apposition, and a separate fine silk buried suture is often used for the fascia only. It may help to explain my description if I show the parts removed in a recent case, occurring about two weeks ago, after the meeting is concluded. The operation is, of course, a minor one, and the wounds heal readily without any suppuration or temperature. By this means the vagina is contracted through its whole length; the recto-vesical fascia is repaired, the bladder is kept up, but the vagina is retained, and no definite function or organ is necessarily lost. I cannot say whether all of the cases operated on in this way will stand the test of time, but so far I have not met with any real failure. In one respect, even as regards the protrusion, I am inclined to think that the method I have described may compare very favourably with that of total extirpation of the vagina. Some cystocele-bulging or impulse was present in the cicatrix of one of the cases Mr. Martin kindly showed me, and this, I think, may be avoided by the cure of the cystocele before repairing the fascia posteriorly. I should like to suggest that even in extirpation of the vagina it might be advisable (if time permitted) to enfold and narrow the base of the bladder by a buried suture before bringing the rest of the wound together. I think that the Society is to be congratulated in having such an original and bold innovation in surgery and such a valuable and interesting paper brought before it by one of our Fellows. As our President as well as his colleague, in thanking him for his communication, I would like especially to notice the fine and virile restraint which has marked his practice. The treatment is, as he has acknowledged, a severe and even dangerous one. He has used it with rare judgment and discretion.

Mr. CHRISTOPHER MARTIN, in reply, said: First let me thank the President and members of the Society for the most kind manner in which they have received and discussed my paper. In reply to Dr. Mansell Moullin, I have never found any difficulty in recognising the fascia and in sewing the edges together. It is a very distinct and definite layer. In reply to Dr. Hodgson, who asked why the bloody effusion broke down into pus, I would point out it was open to two sources of infection—bacteria from the rectum and bacteria from the ulcerated cervix and vagina. Dr. Fenwick asks "Why not leave the anterior wall of the vagina and be content with removing the posterior vaginal wall and sewing up the fascia?" I would point out that this would not cure the cystocele. Ergot and strychnine given with the idea of reducing the size of

the uterus would, I am sure, be perfectly useless in bad cases of total prolapse. Moreover, most of these women are past the menopause. I am interested to learn from Dr. Macnaughton-Jones that Professor Martin, of Berlin, has devised and carried out a somewhat similar proceeding. I appreciate the value of the suggestion of Dr. Macnaughton-Jones that the uterine arteries should be ligatured before the vaginal mucous membrane is dissected off. It would no doubt tend to diminish the arterial bleeding. The most troublesome bleeding comes from the veins of the vaginal plexus, and I do not think that it would prevent this. I am very grateful to the President for his generous remarks. I am pleased to know that he agrees with me in insisting on the importance of suturing the pelvic fascia in operating for uterine prolapse. In all these cases of plastic operations it will be found that the more thoroughly the vaginal mucous membrane is removed, and the more completely the pelvic fascia is brought together, the better will be the ultimate result.

Dr. MACNAUGHTON-JONES read notes of the condition Tuberosa Subchorial Decidual Hæmatoma, and touched on the etiology of the condition as advanced by Breus, Go'dspohn, Newman, Davidsohn, and H. Schroeder. He showed with the epidiascope a specimen of Professor H. Schroeder's of this condition, which he (Dr. Macnaughton-Jones) had recently brought from Professor Fritsch's klinik at Bonn.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF MEDICINE.

MEETING HELD IN THE ROYAL COLLEGE OF PHYSICIANS,  
ON FRIDAY, NOVEMBER 11TH, 1904.

The President, Dr. W. J. SMYLY, in the Chair.

#### SPORADIC CRETINISM.

Dr. KIRKPATRICK showed a child, æt. 4, which at the present time weighs 15 lbs. Two years ago the child was under observation, and then weighed 13 lbs. The child is greatly emaciated and shows little or no signs of intelligence, and has never made any attempt to speak. The skin is clear and soft, and the hair well grown, the characteristic cretinoid aspect being completely absent. There is no history of congenital syphilis, nor are there any well-marked signs of this condition, and though there are some signs of previously existing rickets, there was no evidence of the acute stage of this disease while the child was under observation. No trace of the thyroid gland can be detected by palpation in the neck, and during the last fortnight, while the child has been under thyroid treatment, he has shown some signs of improvement. Dr. Kirkpatrick was inclined to look on the case as a rather anomalous one of sporadic cretinism.

Dr. WALTER SMITH asked, was the possibility of rickets with hydrocephalus considered as a diagnosis, as the symptoms would fit in with that?

Dr. LANGFORD SYMES said that one or two possibilities occurred to him. First, rickets. The head was typically rachitic, with large fontanelles and extreme bossing. There was also some beading of the ribs, though there was a lack of the enormous beading one would expect. Second, there was a possibility of some congenital syphilis. The child's teeth were strongly notched. The abdomen was peculiar, being a very large, protuberant one, and the intestines were apparently a good deal matted. The child was also suffering from great marasmus. There was serious mental defect, and probably some hydrocephalus.

Colonel McNERCE asked, was there any history of consanguinity? He related a case of two first cousins having married, the parents of one being also first cousins. The first child presented exactly the same appearance as Dr. Kirkpatrick's patient. Twins were afterwards born, one like the first child, the other healthy. There was no history of syphilis.

Dr. KIRKPATRICK said he had thought of rickets and hydrocephalus, but since seeing the child first it had

never shown signs of acute rickets, nor was there a history of any acute illness. The condition had developed gradually. Possibly rickets might explain some of the symptoms, but not all. The child was in fairly good health, had no pain, lay quietly in bed, had no fever. He could find no symptoms which would definitely point to congenital syphilis. There was no history of a rash, nor were there any scars on the body. The notching of the teeth went for nothing, as the typical syphilitic teeth occurred in the secondary dentition. Also the child would probably not have remained in its present condition for two years without improving or unimproving. Ten days ago it was put on thyroid extract, and during that period the child had shown signs of improvement. It had shown more intelligence, took more interest in its surroundings, and was more anxious for food.

Dr. TRAVERS SMITH exhibited the four following patients:—(a) A girl, æt. 10, looking perfectly healthy, with no history or signs of rheumatic taint. She had never complained of any cardiac symptoms. A strikingly distinct systolic thrill was felt all over the præcordial area, most marked in the region of the pulmonary artery. The thrill corresponded to an exceedingly loud, rough murmur, most audible in the pulmonary area. The right ventricle was slightly enlarged. A diagnosis of some congenital defect of the pulmonary artery leading to slight stenosis was made by Dr. Smith, who also pointed out that, though the cardiac lesion was unquestionably organic in nature, the murmur was diminished by a full inspiration almost to the same degree as one expects in the case of the so-called pulmonary hæmic murmur. (b) A middle-aged woman with complete loss of perception of tactile, thermal, and painful sensation in her entire skin. The mucous membranes were not affected. The conditions had existed for a week or more. The diagnosis of hysteria was made. She has since greatly improved. (c) A man, æt. 35, who had been admitted to the Whitworth Hospital a year previously suffering from left-sided hemiplegia and hemianæsthesia. Thrombosis of the branch of the middle cerebral artery supplying the right internal capsule was diagnosed, and though a history of syphilis was denied, this was considered the most likely cause. He left hospital after a few weeks very greatly improved. He returned a few weeks ago complaining of typical lightning pains: Argyll-Robertson pupils had developed, and slightly impaired sensation in the feet. The knee-jerk on the left side was still greatly exaggerated, and Babinski's sign was present, whilst the right knee-jerk was almost completely lost. Ataxia was doubtful, even with severe tests. Tabes dorsalis was now diagnosed, thereby confirming the suspicion of syphilis. The persistence of the exaggerated left knee-jerk Dr. Smith considered an interesting point in the case. (d) An elderly woman, who some months ago developed hemi-athetosis affecting the leg, arm, lower part of face, and tongue on right side. There was no history of apoplexy. Dr. Travers Smith had observed her for a fortnight, and came to the conclusion that she was rapidly becoming demented. He considered some variety of cerebral softening to be present.

#### CAISSON DISEASE.

Dr. J. B. COLEMAN made a communication on the subject of caisson disease, as experienced by workers engaged in boring a tunnel for five miles beneath the bed of Lake Erie from and after the year 1897. He mentioned the theories of this disease: (1) Emboli of nitrogen liberated from the blood in consequence of reduced pressure and so obstructing the small vessels and injuring the nerve elements; (2) the toxic effect of oxygen under high pressure; (3) congestion with either acute revulsive anæmia or comparative stasis. The symptoms came on after rapid decompression of one to three minutes. From ten minutes to six hours after reaching normal pressure the patient suffered excruciating pains, usually in his knees, sometimes in shoulders and elbows, rarely in his hips; maniacal attacks supervened occasionally; retention of urine

was common, and in the severe attacks paralysis of the sphincter ani. Paraplegia occurred and lasted for a few hours to months, and in severe cases persisted with the symptoms of spastic paraplegia; transient facial paralysis was seen; an æsthesia extending up to the ribs was common; an intense feeling of pruritus ("the itch") might occur without pains; bleeding from nose and ears; vertigo, dimness of vision, headache, vomiting, and muscular cramps were other symptoms noted. Urgent attacks of dyspnoea ("the chokes") were frequent, during which the patient felt his lungs over-distended; then a cough was set up, and large quantities of gas, seemingly from the stomach, issued from the mouth. Relief from the joint pains and from retention of urine was obtained by a very hot bath. After work the men felt "wearied and bruised," and on returning to the compressed air they became exhilarated and relieved. Except in the most severe attacks the symptoms always abated on undergoing recompression. The highest pressure was 46 lbs. to the square inch.

Dr. WALTER SMITH said the interest of the disease centred in its pathology. The first point was the comparatively moderate pressure which produced the disease. It was sometimes laid down that it requires a pressure of three atmospheres, but this patient had worked under considerably less. The second point was the persistence of the effects; this man was regarded as incurable. Thus a difficulty was raised as to the mechanical theory of causation. It had been proved by experiments on animals that gas embolism could occur, but it puzzled him to understand how a mechanical explanation, especially with a gas like nitrogen, could produce such terrible and long-abiding effects. There was, therefore, some other factor. A direct myelitis was set up, and it was possible that a sudden mechanical disturbance of the pressures might cause not only gas embolism, but also an ebb and flow in the vascular condition. It must cause a shock to the nervous elements, and he did not know what might happen to the protoplasm of the nerve elements. Therefore he thought it premature to suppose that the symptoms were caused by gas embolism only. It was well to examine the converse case, and compare the results of over-pressure with under-pressure, as in balloon ascents or mountain sickness. It was known that below a certain pressure a person would die, owing to diminution of the oxygen tension in the arterial blood. It is not the absolute pressure of the gases, but the increased oxygen tension that is important. There might also be the direct irritant or toxic effect of oxygen gas. As to preventive measures, he thought the method of purifying air and absorbing CO<sub>2</sub> by sodium peroxide should be employed, and the patients provided with it.

Dr. NINIAN FALKNER asked if the presence of marsh gas could account for the symptoms?

Dr. TRAVERS SMITH asked how the purely mechanical theory, namely, that of gas embolism, could be reconciled with the frequent delay of the onset of the symptoms after the return of the workers to normal atmospheric pressure.

Dr. COLEMAN said that his patient got his symptoms worst when going through strata of marsh gas, but got the "chokes" when there was no obvious presence of that gas. In reference to the comparatively small air pressure which brought on the symptoms, the highest pressure the patient worked under was 46 lbs., about three atmospheres. No theory would satisfactorily explain all the symptoms of the disease, and it was not unlikely that two or three conditions were necessary to bring it about. It was likely that the disease was caused by gaseous emboli of nitrogen acting mechanically, or by oxygen from a direct irritant effect. In reference to therapeutics he was not aware that peroxide of sodium had been used, but the method of ventilation was to pump in large quantities of fresh air, the air escaping from the lower end of the caisson. His patient found that when the symptoms were coming on, they were arrested if he went back into the compressed air. Medical locks were in use in well-regulated works; the men were treated

there, and decompression was gradually produced. As to the delay in the onset of symptoms, in some cases they did not come on for hours, though it was likely that any gas which was going to escape from the blood did so almost immediately, but the mischief had already been done to the nerve elements.

#### Dr. G. PEACOCKE described two cases of HODGKIN'S DISEASE

that occurred in twin boys, æt. 4. One of them had died eighteen months after the glandular enlargement first appeared. At the time of his death the glands on the right side of the neck and a few in the right axilla were enlarged. The spleen reached as low as the umbilicus. The red cells numbered 1,300,000 per cm.; hæmoglobin, 15 per cent.; white cells, 8,000 per cm.; differential count—lymphocytes, 21 per cent.; polymorphs, 86 per cent. The other boy, whose illness dated from last February, was still alive, and his general condition satisfactory. Some greatly enlarged glands in the left side of his neck had been removed a few weeks previously. Microscopic examination showed the enlargement of the glands was due to a general increase of the cellular portion of the glands. His spleen was not enlarged and a blood count showed red cells 4,000,000 per cm.; hæmoglobin, 85 per cent.; white cells, 8,500 per cm.

#### WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, NOVEMBER 4TH, 1904.

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

#### CLINICAL MEETING.

Dr. P. S. ABRAHAM showed (1) a case of "scleroderma with bullæ and ulceration," occurring in a woman aged 55 years. The progress of this case was remarkable and probably unique, as bullæ, which usually do not occur in sclerodermic integuments, formed about the knees in this patient six months after the onset. (2) A remarkable case of "keloid," the result of a burn from a gun-cotton explosion at Woolwich two years ago.

Dr. A. E. RUSSELL showed a case of "tabes dorsalis" with gastric crises in a patient 42 years old. He evinced very typical symptoms which are of two years' duration, and accompanied by severe gastric crises, being associated with troublesome vomiting, which resist ordinary treatment.

Dr. A. E. RUSSELL also exhibited for Dr. A. P. Beddard (1) a case of "tremors," the patient being a man, 27 years of age, who went through the siege of Ladysmith, where he contracted typhoid and dysentery, after which the tremors appeared at irregular intervals, involving chiefly the hands, and to a less extent the head and lower limbs. Dr. Russell considered this case to be functional in origin, there being no symptoms of organic lesion.

He also exhibited a case of (2) "myositis ossificans" in a man aged 37 years, which had developed slowly since the age of seven years. Bony growths are felt in the muscular system in innumerable positions in the form of bony masses in the tendons and insertions of the muscles, causing great impairment of movement of joints, several of which are ankylosed, rendering him quite helpless.

Mr. A. BALDWIN considered there was some relationship between this disease and pseudo-hypertrophic paralysis, also hæmophilia, and transmitted through the females to the males of the family.

Dr. A. GASTER related that he had a family under his observation in which the grandfather, father, and three sons had the disease, whereas the mother and two daughters had escaped.

Mr. ASLETT BALDWIN showed a case of "tabes dorsalis" with Charcot's disease of tarsus, in a man, æt. 34 years. The disease apparently commenced in 1900, after a slight injury to the feet, and since which time the enlargement of the feet has slowly progressed. He could walk very well until August, 1904, when the right foot suddenly commenced to



turn inwards, necessitating the wearing of irons to keep the foot straight. He exhibits well-marked symptoms of locomotor ataxy.

Mr. G. A. GARRY SIMPSON showed (1) a case of "clonic spasm of soft palate" in an unmarried woman, *æt.* 40. This affection arose about a year ago, when she received a severe shock owing to the sudden death of a brother. The contractions of the velum palati are at the rate of 60 per minute, and are accompanied by a clicking sound audible to the patient and to those around her. There is no irritation of nose or pharynx to be discovered, and the muscle principally involved is the levator palati supplied by the facial nerve; (2) "pharyngomycolosis leptothrix," the subject being a married woman, *æt.* 27 years, whose attention was first drawn to the disease by having a constant disagreeable taste, and having hard, white, chalky substances on the tonsils. The disease is associated with the leptothrix fungus, a specimen of which Mr. Garry Simpson exhibited under the microscope. He considered that the leptothrix forms a nucleus in the tonsillar crypts and accumulates altered cells and debris.

Dr. BALL was of opinion that local treatment was of very little use, he having tried all kinds of germicides, which only led to disappointment. He considered the leptothrix as accidental, and not the cause of the disease.

Dr. NEVILLE WOOD asked whether the disease has become more common of late, as recently he has had a number of such cases under his observation.

Mr. COLE MARSHALL showed Dr. E. P. Paton a case of "misplaced testicle" situated in the left side of the perinæum. The testis is surrounded by a hydrocele, with a hernia, probably sciatic.

Mr. DONALD ARMOUR showed (1) a case of "ankylosis of jaw" in a girl, *æt.* 24 years, who is one of six children, who are all living and well. Her jaw has been ankylosed since infancy, and the jaws cannot be separated. The teeth (two central incisors) have been broken to enable her to get food into the mouth, and she masticates with the tongue. There is no paralysis of the masseter or temporal muscles. No cause can be attributed for this condition, unless possibly a fall downstairs in infancy, which has left a scar on the chin. (2) "Parotic swelling," commencing in a man ten weeks ago, associated with pain at base of zygoma, which was periodical. Two weeks ago he began to have difficulty in opening the mouth. The swelling is limited by the parotid fascia, and is slowly increasing, and the paroxysms of pain are increased with a point of tenderness over the base of the zygoma.

Dr. PARDOE did not think the swelling to be connected with the temporo-maxillary joint, although this joint is specially liable to attacks of gonorrhœal synovitis. He considered it to be a case of suppurative parotitis.

Mr. BALDWIN also considered it to be a case of suppurative parotitis, and suggested excision of the gland and examination of the pus.

Dr. ARMOUR also showed (3) "hypertrophic pulmonary osteo-arthropathy" in a man suffering from syphilitic synovitis of knee-joint.

Dr. A. M. ROSS SINCLAIR showed an interesting and rare case of "paralysis of the cranial nerves," in a woman 29 years of age, who first complained in the beginning of September of pain in swallowing solid food, irritable cough, and hoarse voice, with loss of weight. The right side of tongue, soft palate and vocal cord on same side were completely paralysed, together with the sterno-mastoid and trapezius muscles. The patient's sensory, motor, and reflex functions are otherwise normal. The lesion, he considered, was probably due to syphilis contracted seven years ago, and there is probably a gummatous thickening of the membrane at the base of the medulla. The patient is improving under specific treatment.

#### THERAPEUTICAL SOCIETY.

At the third annual meeting of this Society, held at the Apothecaries' Hall, Blackfriars, on October 25th,

1904, Sir WILLIAM THISELTON DYER in the Chair, Sir Lauder Brunton was elected President of the Society, and Dr. H. French Assistant Secretary. The thanks of the Society were given to Sir W. Thyselton Dyer, for his services as President of the Society from its commencement.

In response, he said that under the Presidency of Sir Lauder Brunton the Society was certain to prosper. It was then agreed that in future candidates should be elected by the general meeting of the Society.

Dr. ARTHUR HARRIES then read a paper on "Some Applications of the Continuous Current," which he said might act either mechanico-physically by cataphoresis; electro-chemically, termed electrolysis; or electro-physically, called catalysis, and he gave illustrations of benefits from each of these actions in cases of rachialgia, arthritic and other affections, also in cases of stricture, disease of prostate and lupus.

Dr. GEORGE CRICHTON read a paper on the "Metric System in Dispensing," showing the great inconvenience of the present system, which consists of three entirely different measures—the pound, the drachm, and the fluid drachm and minim, causing much difficulty in correlating these. In prescribing, the gramme is nearly one-quarter of a drachm, and one-fifth of a centimetre is nearly three minims. Mistakes owing to the wrong position of a decimal point ought not to occur if proper care is used in writing prescriptions.

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 20th, 1904.

#### A SIGN OF PHELGMONOUS TONSILLITIS.

PROFESSOR VINCENT, of the military hospital of Val de Grâce, has described a new sign of quinsy—contraction of the pupil on the same side as the phlegmon. The patient standing in an average light, it is easy to observe the inequality of the pupils. It is true that this unilateral myosis also accompanies other forms of sore throat, but it is very inconstant and but slightly perceptible. It is, on the contrary, very frequent in phlegmon of the tonsil, and persists with the malady even several days after the abscess has been evacuated. The explanation of this phenomenon is embarrassing. The contraction is probably the result of a special reflex, and this reflex originates in the velum of the palate, for it appears only when that region is affected. According to one authority, Meckel's ganglion and the ophthalmic ganglion are, in some individuals, in direct communication one with another, and that fact could explain that a painful unilateral inflammation taken by the palatine nerves might, in a reflex medium of which the spasmodic centre is Meckel's ganglion, produce the contraction of the iris on the same side.

#### TREATMENT OF BURNS.

The fundamental division of burns is as follows:—(1) The burn is recent; (2) the burn has existed for several days and has been modified by more or less prolonged suppuration. As regards the former, the accident has just occurred, and no application has yet been made. What is to be done? The treatment will differ according to the gravity of the lesion and the degree of the burn.

If it is a case of the first degree (erythema), an application of vaseline and cocaine (1-100), covered with a sterilised compress, will be sufficient to relieve the pain. If the burn be of the second degree, if it be accompanied by phlyctena, these should be scrupulously respected. The common practice of piercing the skin to let out the serosity should not be followed. It is sufficient to cover the region with a compress wet with a solution of picric acid (1-100), and finally a thick layer of carded wool maintained with a bandage. This dressing should not be disturbed for three or four days. If the bullæ are already opened the treatment will be

that of the third degree, or that of ulceration, which consists in antiseptic washing of the parts and applications tending to provoke the renovation of the epidermis.

The antiseptics of the region consists in carefully cleansing the immediate healthy skin and the lesion itself. If the patient is courageous enough, this operation can be done without anaesthesia. But if the lesions are extensive and the patient cannot support the suffering, it is preferable to have recourse to local anaesthesia with stovaine, or, better still, to general anaesthesia. The bullæ will be completely opened with scissors, sterilised in the flame, so as to lay bare the wound. The ulcerations will be carefully washed with soap and warm water so as not to lacerate the tissues, and the soap removed by compresses of boiled water, and, finally, the region will be washed with ether and alcohol. The wound will then be covered with a dressing of picric acid solution, as in the first case, and a thick layer of cotton wool. The dressing will not be removed for four or five days, when the ulcerations will be generally cicatrised or partly healed. Care must be taken not to take off the dressing roughly for fear of destroying the new skin.

In case of extensive burns, therapeutics are generally of little avail. It is the general condition of the patient that should be attended to. Warm baths, according to the Hebra method, may be of some use. Burns of old standing are those badly treated at the beginning and arrived at the stage of suppuration. They are no longer burns, but ulcers without tendency to cicatrise. The region should be carefully cleansed as above and for three or four days oxygen water (12 volumes) should be applied. In certain cases oxygen water is ill tolerated; it can be replaced by compresses of boiled water. After this period of wet dressing, when the wound will have been properly cleaned and granulations will have begun, peroxide of zinc (ectogan) will be applied.

The wound generally heals very rapidly under this treatment.

#### TREATMENT OF HYDROCELE.

Withdraw one or two drachms of the liquid and inject half a Pravaz syringe of a solution of adrenalin (1-1,000). Repeat the operation eight days after. By this method a rapid cure is effected.

#### ANOTHER TUBERCULOSIS CURE!

The explorer, Dathan de Saint-Cyr, whose researches on the cure of consumption by a West Indian plant have been frequently referred to, has just placed his thesis on the subject before the Paris Académie de Médecine, which will investigate the claims made for the remedy by its author.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

Berlin, November 19th, 1904.

At the Medical Society, Hr. P. Marcuse showed a boy suffering from

#### MICULICZ'S DISEASE,

so named from having been first described by that surgeon. The lachrymal glands, as also the whole of the salivary glands and those of the heart—the parotid, the submaxillary, the sublingual and Nuhn's glands—were all enlarged and formed well-defined rather soft tumours, not painful, and easily movable under the skin. The disease began three months ago with pain in the head and neck, and the day after the lumps were felt. The lachrymal secretions had ceased entirely, and the salivary secretion almost; the small quantity of salivary secretion contained no cyanid of potassium. The urine was free from sugar, and the blood was normal. There was not much distress. The speaker thought the cause was some infection. Therapeutically potassium iodide arsenic, and massage had been advised.

Hr. Westenhoefler spoke on

MEAT INSPECTION WITH REGARD TO TUBERCULOSIS.

He said that in a previous address he had stated that the flesh of tuberculous animals contained no tubercle bacilli except in the cases of acute miliary tuberculosis, and he was now in a position, as a result of his continued investigations, to support this view. He implanted pieces of muscle from tuberculous animals into guinea-pigs, which were known to be extremely susceptible to tuberculosis, but always with negative results. Of seven animals inoculated from animals suffering from acute miliary tuberculosis four only became diseased.

When the direct implantation of the flesh of tuberculous animals into guinea-pigs gave only a negative result, it was not to be wondered at if feeding them with such flesh set up no disease.

He suggested, therefore, that only the flesh from tuberculous organs (bones and joints), as well as the flesh of animals suffering from acute miliary tuberculosis, or animals much emaciated from tuberculosis, need be destroyed, and that the flesh of animals suffering from internal tuberculosis was fit for food. If axillary glands or those of the legs were diseased, the whole of the quarter need not be destroyed.

According to recent regulations, meat from the country that had undergone veterinary inspection at the place of slaughter did not require further inspection before being sold in the city. Independently of the country veterinary not being so well skilled in meat inspection as their specialist *confère* in the city, he was also to a certain extent dependent on the person employing him, and he might, therefore, be not quite so strict as he should be. As a matter of fact, 1 per cent. of the meat inspected in the city control stations that had been killed in the country had to be rejected. Country slaughterhouses should be in central localities, and only fully paid inspectors independent of private practice should be appointed. Until that was done meat from the country could not be beyond suspicion.

In the Dermatological Section of the Naturforscherversammlung, Hr. Strebel spoke on the use of CATHODAL RAYS AS A SUBSTITUTE FOR RÖNTGEN AND RADIUM RAYS.

In their action the speaker said they resembled radium rather than X-rays. In two cases of cancer, and various patches of lupus, ray-emanation of eight to ten minutes sufficed to cause moderate reaction, and, on this, absorption of infiltration. The advantage of this process lay in its being able to replace the very expensive and hardly procured radium. He then described the advantages of his photocaustic, which was a useful complement to Finsen light treatment, one advantage being that after cauterising to the third degree the cutaneous nerves were destroyed, so that when the patient woke up after the operation she did so free from pain. Photocaustic could also be employed in the consulting room by making use of a cooling apparatus that he had devised. In three cases of severe and intractable X-ray ulcer, that had resisted all treatment for a year and longer, healing was brought about in four or five weeks by the use of the photocaustery. The glow-light treatment in diseases of the urethra was perfectly ideal; any stage of inflammation could be set up at will, from simple erythema blistering, and with the certainty that after the artificial inflammatory process had subsided there would be no danger of subsequent stricture. The pure light reaction was the strongest; with later reaction the rays must be used longer.

Mrs. D. Lydia Rabinowitsch, who, in consort with Dr. Max Köch, had examined a large number of birds from the Zoological Gardens, spoke on

#### BIRD AND MAMMALIAN TUBERCULOSIS.

Of 200 birds of the most varied kinds, about 25 per cent. were tuberculous. The disease appeared to commence in the digestive organs. Pulmonary tuberculosis was more frequent than it had been understood to be. The danger of infection from bird to bird was not great; it lay mostly in eating the excreta of diseased animals, or feeding on infected rats or mice. The bacilli of bird tuberculosis might invade mammalia. Mammalian tuberculosis was found in two eagles; this form had

hitherto only been met with in parrots. The culture of pathogenic properties of bird and mammalian tuberculosis were different. Transitions and certain variations in toxic property were observed in some strains. Attempts to change one kind into another by experiments on animals were but rarely successful.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 19th, 1904.

### ORTHOSTATIC TACHYCARDIA.

At the last Breslau meeting, Thomayer recorded three cases of tachycardia in which the pulsations were normal when the patients lay down, but immediately the body was raised into the normal attitude the tachycardia was aggravated. This being a rather unusual form of the morbid condition, he has designated it orthostatic tachycardia, which depends for its origin upon some weakness at the bulbar centre, producing lowering of the arterial blood-pressure on the vessels when the body is erect. He is of opinion that this orthostatic tachycardia is particularly confined to the origin of the vagus in the bulbar centre, which is proved by intoxicants acting on this centre.

In the horizontal position the liquor cerebro-spinalis, which seems to be the exciting cause, is allowed to be more distributed, but when the head is raised the pressure is increased and produces the morbid symptom. In support of this hypothesis he quoted from a number of experiments performed on healthy persons where the pulsation is greatly reduced immediately the head is depressed below the pelvis. In this position the pulsation is slower than in the horizontal and still less than in the vertical position.

### OTOGENIC MENINGITIS WITH RECOVERY.

At a meeting of the Naturforsch. Fischer related the history of a case of meningitis in a young man, æt. 19. The illness commenced with great pain in the head, vertigo, and loss of consciousness, but no convulsions or vomiting. On the second day of the disease the temperature rose to 38.9° C. (102° F.), the pulse 100 with a difference in the size of the pupils, left facial paralysis, stiffness in the neck, Kornig's symptom, and a very high state of hyperæsthesia in the sensory nerves. There was also otitis with rupture of the tympanum.

Puncture of the membranes of the spine in the lumbar region emitted a cloudy cerebro-spinal fluid under great tension. The fluid was rich in leucocytes, but no organisms could be found either by culture or inoculation. After this the patient gradually improved for five days, when the puncture of the lumbar region was repeated, by which a clear fluid was obtained this time. On the sixth day a new complication appeared in the form of typical croupous pneumonia, which reached a crisis on the tenth day of the disease. After this period he gradually recovered, and is now quite well.

Such prominent symptoms could not be explained on any other ground than a secondary meningitis from the otitis, and forcibly proves that all pustular centres should be cleared out as soon as possible.

### BLOOD-PRESSURE.

Hürtle gave a historical account of the experiments on, and writers who have attempted to elucidate, this subject. Pressure and velocity have engaged the attention of Volkmann, Ludwig, &c., who conducted their experiments with chromic colours, which are rather fallacious as the resistance is an uncertain factor. If velocity, index pressure, and resistance be represented by V, I P, and R, the equation for velocity would be  $V = J(P R)$ , but as we know so little about the resistance the blood meets with on its course, both internal and external, the former depending on the viscosity of the blood, the latter on the dimensions of the vessels. The greater the viscosity the greater the internal resistance; and as the normal blood of the dog is four to five times that of distilled water at the same temperature, by means of this

value we can arrive at the external pressure in the equation which may be confirmed by the bromindex. Hürtle gave a few formulæ from authors on the subject, which were quite erroneous, and demonstrated one case where he proves that the velocity of the blood in the artery falls quicker than the pressure.

### DEAFNESS IN SCHOOL.

Konig, as medical officer of health in Westphalia, has selected a particular small town in his area for exact observation, and gives us the following:—From 787 children, 289, or 36.7 per cent., had normal hearing; 498, or 63.28 per cent., had defective hearing; 432, or 54.8 per cent., being bilateral. In analysing the defectives 9 per cent. had discharging ears, 17 per cent. enlargement of the pharyngeal glands, 14 per cent. enlarged tonsils, while 60 per cent. suffered from catarrh of the Eustachian tube and middle ear. In the whole school 15 per cent. of the boys would be exempted from military service owing to deafness. Only 2½ per cent. were actually conscious of deafness or any defect about the ears. He thinks the State should see to the treatment of these children as part of its duty.

### EOSIN LIGHT TREATMENT.

With the advances of light treatment every device seems to be resorted to with satisfactory results. Pick, of Prague, has obtained all the beneficial results if not better than those accomplished by the Röntgen rays. The morbid part is painted over with a 1 per cent. solution of eosin and then exposed to the sun's rays.

The long series of cases treated in this way includes twelve of lupus, five of trichophytis, three of sorofula dermis, and one case of tuberculosis cutis verrucosa, with ulcus rodens. In the lupus cases the inflammatory appearance receded in a very short time after commencing the treatment and consequently the hypertrophic tissue soon disappeared. In no case had he yet met with any bad after effects. The trichophyte cases healed in a few days, while the ulcus rodens lingered about a week after, before perfect healing was accomplished.

## The Operating Theatres.

### LONDON HOSPITAL.

OPERATION FOR SINUS FOLLOWING APPENDICULAR ABSCESS.—Mr. F. EVE's patient was a boy, æt. 15, who had been operated on for appendicular abscess in the country more than a year ago. The sinus having persisted, he had been operated on two or three times subsequently. Mr. Eve remarked that a sinus following an appendicular abscess may be due, first, to the sinus communicating with an appendix which had been perforated, the appendix not having been destroyed by the abscess; secondly, to a fecal concretion which had not been removed when the abscess was evacuated; thirdly, to a silk suture when the appendix had been removed, therefore catgut sutures should always be employed; fourthly, the abscess may have burst into the cæcum or other part of the bowel; fifthly, the original disease in the appendix may have been tuberculous—a tuberculous sinus persisting after the operation; sixthly, as a rarity the original disease may have been actinomycosis. It was often stated, Mr. Eve pointed out, that the appendix was usually destroyed or rendered obsolete in those cases in which abscess formed, but this was by no means always the case. Therefore, patients should be warned that a fistula may follow in those instances in which it has been found impossible or inadvisable to remove the appendix. As regards the operation itself, he said the most important point was to open the abdomen sufficiently freely by an incision at a distance from the fistula. If the fistula

were laid open directly, the peritoneal cavity might also be opened at the same time and thus infected from the fistula; and, further, the bowel would probably be found adherent to the parietes and might be injured. The method of making the incision at a distance from the fistula allowed the surgeon also to make a thorough inspection of the interior of the abdomen and to separate adhesions when necessary before the sinus itself was interfered with. In the case under observation the fistula was situated a little above and internal to the anterior superior spine. An incision was made to the inner side of the fistula and an inch and a half from it. The peritoneal cavity was freely opened, and the area of operation packed off with gauze from the general peritoneal cavity. The fistula was then laid open, and it was found to terminate in the distal end of an appendix about an inch long, which apparently had been separated from the main body by sloughing. The proximal part of the appendix had apparently been removed at a former operation, as the stump was found attached to the cæcum. The sinus and portion of appendix were removed. The wound was then thoroughly cleansed, the packing removed, a gauze drain inserted, and the wound closed.

#### ST. PETER'S HOSPITAL FOR STONE.

A CASE OF COMPLETE PROSTATECTOMY FOR ENLARGED PROSTATE.—MR. THOMPSON WALKER demonstrated a case on which he had performed complete prostatectomy six weeks previously. Before operation the patient, æt. 66, had suffered from complete retention of urine for five years, and previous to this from increasing frequency of micturition for four years. During the five years previous to operation he had passed his catheter four times daily, but not at night. During the last month he had frequent desire to micturate and had passed his catheter about every hour and had caused bleeding on each occasion. There was recurrent left epididymitis. His prostate per rectum was moderately enlarged, rather soft and movable. With the cystoscope a well-marked projection into the bladder was seen. There was slight cystitis, but no vesical stone. The bladder was first washed out until the fluid became quite clear, it was then distended with twelve ounces of boracic solution and the coudée catheter plugged and left in position. On opening the bladder above the pubis at the operation, a well-marked collar-like intra-vesical projection of the prostate was felt with the left forefinger in the rectum pushing the enlarged prostate upwards. The prostatectomy was commenced by scraping through the mucous membrane covering the most prominent part of the collar; the mucous membrane stripped off readily before the finger, which was then passed onwards between the prostate and the vesical sphincter; the finger then slipped between the fibrous sheath and the capsule of the prostate and was swept round the extra-vesical part of the right lobe; without removing the finger from its position between prostate and sheath it was swept across the middle line, passing behind the prostatic urethra and left lobe of the prostate. The enucleation was continued by raising both lobes with the finger so that they were separated from the sheath as far as the membranous urethra. The prostate still remained attached at the junction of the prostate and membranous urethra and along the middle line anteriorly. By forcing the enlarged gland upwards these connections

were torn through and the prostate was projected into the bladder by the forefinger. A pair of sharp toothed forceps were introduced into the bladder, and grasping the prostate removed it from the suprapubic wound. The nozzle of an irrigator was then connected with the catheter, which still remained in position, and very hot boracic lotion was introduced into the prostatic cavity and bladder and welled up through the suprapubic wound. The lotion at first was blood-stained, but very rapidly became quite clear, and there was no further bleeding. A large drainage-tube three-quarters of an inch in diameter with a side opening near its lower end, was then introduced into the bladder. The bladder was again irrigated and the catheter removed. The rectum muscles were brought together by a single stitch and two other skin stitches were introduced. There was no collapse after the operation, and no further bleeding. Irrigation of the bladder was commenced twenty-four hours after the operation, the drainage-tube being washed out with fluid from the irrigator, but not removed. In forty-eight hours irrigation through the urethra was commenced without the aid of a catheter, and was repeated daily. A little urine was passed along the urethra on the twelfth day after the operation. From the fourteenth day urine came regularly by the urethra in increasing amount. The suprapubic bladder wound closed on the twentieth day, and the patient left the hospital four weeks after the operation. He is now, six weeks after the operation, in perfect health. His stream, as was seen at the demonstration, was powerful, commenced at once, and did not dribble at the end. He makes his water three times during the day, and does not rise at night unless he drinks beer, after which he gets up once. His urine is still slightly cloudy. Examination of the rectum shows a loose empty sac in place of the prostate; below this the median ridge of the membranous urethra is readily felt, at the upper end of which a small nodule the size of a split pea can be detected.

Mr. Thomson Walker's remarks on this case will appear in "Operating Theatres" of next week.

#### Trinity College, Dublin.

THE following have passed the Final Examination in Medicine—Section A, Michaelmas Term, 1904:—Ralph S. Oldham, John du P. Langrishe, John C. P. Beatty; Francis R. Coppinger, John W. Tomb, equal; Robert B. Jackson, Thomas O. Graham, Thomas H. Peyton, Francis O'B. Ellison, Thomas J. Cobbe, Henry D. Drennan, Edward Gibbon, Michael P. Leahy, Thomas L. de Courcey; Joseph H. Elliott, Dudley F. Torrens, equal; Basil G. Brooke, Daniel M. Corbett, Reginald Holmes, equal; John Murdoch, James E. M'Farlane, Ernest D. Caddell, Francis Casement, Joseph P. R. Poch, George E. G. Vickery, Joseph C. A. Ridgway.

#### Conjoint Examinations in Ireland.

DIPLOMA IN PUBLIC HEALTH EXAMINATION, AUTUMN, 1904.

CANDIDATES have passed this examination as under-noted:—*Honours*.—John Arnallt Jones, M.D. Durh.; M.R.C.S. Eng., L.R.C.P. Lond., L.S.A. Lond. *Passed*.—Samuel John James Kirby, L.R.C.P. Ed., M.R.C.S. Eng., L.S.A. Lond.; Frederick Charles Willmot, L.R.C.P. and S. Ed.; James Wood, M.B., Ch.B. Victoria; Thomas James Wright, L.R.C.P. and S.I., R.A.M.C.

#### Royal College of Surgeons in Ireland.

*Dental Examination*.—The following candidates having passed the necessary examination have been admitted Licentiates in Dental Surgery of the College: L. Ellenbogen, B. Jackson, W. Matthews, and J. J. Murphy. The following candidate passed the primary part of the examination:—T. J. Bradley.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 23, 1904.

**SWEDISH PHYSICAL CULTURE AND UNQUALIFIED MEDICAL PRACTICE.**

THE medical profession is called upon yearly to face new forms of competition by unqualified persons. The evil has recently assumed a number of more or less subtle and semi-scientific disguises. The beauty doctors, for instance, study medical books on skin, hair, and minor surgery; and they proceed to deal forth the flimsy knowledge thus gained at exorbitant rates to credulous clients. The results are no less disastrous than pathetic. Highly skilled and honourable members of the medical profession, who have fulfilled all the terms demanded by the State, as a condition of legal qualification, are condemned to lives of prolonged struggle, and often of actual penury. On the other hand, owing to the defectiveness of the laws and to the listless apathy of the medical profession, the quack flourishes apace, and piles up wealth at the expense of the health, and sometimes of the lives, of his victims. A Bond Street beauty doctor, to take a concrete instance, has lately formed her business into a large limited company, with branches in many parts of the Kingdom. In the same street a well-known hair-dresser makes appointments and receives guineas for consultations upon the hair. One grave aspect of the matter is that these abuses show no sign of decrease. The public has not yet learned to assess medical science by its successes rather than by its failures, the latter of which clearly open the door to the quack. In the matter of electrical treatment medicine has achieved great strides within the last few years. These advances, among which may be mentioned X-ray therapy, electric batteries and the high-frequency current, have at once been seized upon by a horde of unqualified persons, who advertise widely as being willing and able to cure a number of diseases at various homes, institutes or private establish-

ments. The General Medical Council professes itself powerless to do anything towards stemming this current of illegitimate practice. That august body does not venture even to draw up any recommendations or suggestions to the Privy Council or the Government, with a view of defending the interests of the public no less than of the medical profession in a matter vital to the interests of both. The British Medical Association has made various hitherto futile efforts to promote discussion. The Colleges and other qualifying bodies make no attempt to defend the professional rights and interests of their former pupils. Often where a little plain speaking on the part of prominent men in the profession would nip a threatened evil in the bud, the words of warning remain unspoken. In the case of the recent midwives legislation, for example, the united protest of a score of leading men in the medical world might readily have saved the profession from the indignity of being faced with another set of unqualified practitioners, recognised and legalised as they now are by the State. So far from opposing the step, it has been publicly upheld and supported by various prominent consultants who are obviously out of touch with the thoughts, wishes, and aspirations of the general practitioner. One of the most recent attempts to foist upon the British public a new set of unqualified competitors is the proposal to found a college for the teaching of physical education after the model of the Royal Swedish Institute of Sweden. The Bishop of Bristol presided, and the chief apostle and advocate of the project was a Miss Theodora Johnson, who presides over the destinies of a Swedish Institute in Bristol. The lady urged that a national college should be established, with a charter to receive both men and women. The objects would be, as in Sweden, to license massage, and to teach hygiene and physiology. Sir William Church, who was present, pointed out that, in his opinion, the physical deterioration was due to poverty rather than to lack of knowledge of hygiene and systematic exercise. Sir Lauder Brunton received the proposal with faint praise. It would have been more reassuring to the medical profession, and more helpful to the public, had both these gentlemen condemned the proposal in the unsparing fashion it deserves. If they care to inquire into what is going on at their doors, they will find that Swedish massage practitioners are quartered in some of the best streets of the West End of London, where they are carrying on a flourishing practice. Now or never is the time to settle whether this new race of unqualified competitors is to invade our towns. To a great extent this question could be disposed of by the medical profession, were it able to speak out with clear and united voice. Meanwhile we devoutly hope and trust that medical men of all ranks will henceforth decline to have anything to do with this unclean thing, now that its real nature has been clearly and emphatically stated in the columns of a medical journal.

## SUTURE OF THE HEART.

It is less than nine years since the first recorded attempt was made to treat a wound of the heart by suture. Though unsuccessful, its example was soon followed, and the general result has been so good that it is now regarded as the duty of a surgeon, when called to attend a patient with a wounded heart, at once to cut down and attempt to suture. There are, in fact, at present sixty cases of this sort on record, with no less than twenty-three recoveries. This gives a recovery-rate of 38 per cent., instead of a rate, in cases where suture was not performed, certainly not exceeding 10 per cent. The great majority of the wounds treated were caused by stabbing, but of five gunshot wounds of the heart two have recovered. The usual method of exposing the heart is to cut through two or three ribs some inches from the sternum, and bend the flap thus formed to the right, fracturing the cartilages close to the sternum. The pericardium is then opened, and the heart steadied with the left hand while the stitches are inserted. If necessary to check bleeding, the little finger may be thrust into the heart wound during the passage of the needle. It was formerly held that the stitches should only be inserted during diastole, but recent operators think this an unnecessary precaution, and, indeed, often the pulsations of the heart are so irregular as to render the distinction of diastole and systole impossible. It is advised, too, that cessation of the heart's movements should not interrupt the insertion of the sutures. With a quiescent heart, the work can be concluded in a short time, and a little rhythmical manipulation will then probably be sufficient to restore the cardiac movements. An interesting question arises as to the advisability or otherwise of taking elaborate antiseptic precautions. It is obvious, on the one hand, that time may be a matter of urgency, and that no unnecessary delay is to be made before reaching the injured organ. On the other, it is of the utmost importance that the parts should not be exposed to septic infection. In one unsuccessful case recorded by Dr. J. H. Gibbon, of Philadelphia, he believed his failure was due to the delay entailed in cleansing the seat of operation. He concludes that with patients who are in imminent danger it is wise to expose and repair the heart with the least possible delay, while with others who have lived some hours after the injury, or in whom symptoms are not so urgent, time should be taken to practise precise antiseptic precautions. In the great majority of cases recorded the ventricle—left or right—was the part wounded. Curiously, considering its relation to the chest-wall, the left ventricle suffered more frequently than the right. Only two cases of wound of the auricles are mentioned, and in each case a fatal result followed. Considering the previous mortality of wounds of the heart, the results of surgical interference are very encouraging, and the improvement in surgical *technique* which is sure to follow increased practice should give still better prognosis in this serious condition in the future.

## SANITATION AND ART.

WHEN the history of the nineteenth century comes to be written, not the least striking among the many notable features to be recorded will be the development of the science of hygiene that characterised the latter half of its course. Before the Public Health Act of 1848 hygiene as a recognised communal obligation could hardly be said to exist, the previous enactments having been generally conceived in haste to meet exigencies, and more honoured in the breach than in the observance when those exigencies had passed. Certain glaring nuisances were provided for by legislation of one kind and another, but no consistent, enlightened, or far-seeing body of regulations, or provisions against the evils of human aggregation, were in force. Even to-day sanitary science is only in an embryonic condition, consisting, as it does, chiefly of a patch-work of bits from other sciences and a number of still empirical deductions made from them. Still, it has already definite results, and unquestionably hygiene has come, not only to stay, but to make itself of far more weight in the community. Till now the sanitarian has been looked upon by the majority of people as rather a bore, and as his teachings and advice run counter to many cherished traditions and privileged prejudices, it can hardly be a matter for wonder that public appreciation of sanitary science has not been of a very enthusiastic character. The knighthood just conferred on the London County Council's Medical Officer of Health may perhaps be taken as a presage that in future the man who lives to save lives and preserve health will be considered as worthy a candidate for public reward as is the man who kills the most of the country's enemies, or he who brews the most beer. In spite of its many benefits to society, however, hygiene is still unpopular, and till that unpopularity has worn off it will be difficult or impossible to establish those conditions under which people may live together comfortably and happily without being a source of danger to their neighbours, or themselves subject to many kinds of preventable dangers. It has been said that care for sanitation is the last teaching that reaches the civilised, and if this be so, the sanitary arrangements and institutions of a nation may be taken as a gauge of its general advancement in the comity of nations. But there is another teaching that comes late in a nation's life, and that can be of inestimable service to sanitation if sympathetically allied with it—we mean art. Art can only be developed when the more immediate necessities of existence have been supplied and a margin of the nation's resources can be diverted from the more pressing business of fighting enemies and obtaining food, and though the British people are not in themselves an especially artistically disposed people, they have already evolved a more than creditable school of native art, and are more or less capable of being influenced by it. The failure of sanitation to take hold of people's imaginations and enlist their sympathies has been



Due to the facts that its teachings have been formal, and its influence has been for ugliness. Doubtless it is difficult to a new science which is essentially utilitarian in its object to appear ready-garbed in attractive guise, but we feel sure that while yielding nothing in principle, hygiene would be made far more acceptable if it came linked with art. The civilising influence of sanitation, too, would be greater, and art loses nothing in dignity by being useful. In matters of dress the clothing best adapted to the physiological requirements of the body is generally objected to by people to whom it is recommended, because it is not becoming, and not unnaturally the owner of a pretty house resents having its lines broken and its appearance spoiled by outside soil-pipes—even by the most irreproachable plumber. Waterworks spoil many a rural scene; ventilating-shafts deface the finest streets, and rooms without carpets, curtains and pictures are cold and unattractive. What is first needed is a standard of taste and artistic perception in sanitarians, so that their creditable enthusiasm for the cause they have at heart may have increased enthusiasm with their fellows, and what is secondly needed is some artist who can do for sanitation what Morris did for house decoration. That sanitation should be synonymous with ugliness to the public mind is a vast pity, and we venture to think that the antagonism is more plausible than real. The truth would seem to be that sanitarians have been bent on producing a standard of scientific and practical excellence in the articles and institutions with which hygiene concerns itself, and that they have not yet had time to introduce the element of elegance and refinement into their construction. The public, on the other hand, have already had their eye trained to look for beauty in the objects that surround them, and objects like drain-pipes, that have no pretence to beauty, repel and disappoint them. Now, it is well recognised that art that is developed merely in response to the demands of commerce and manufacture never can secure the same height of greatness and originality as if left untrammelled by such considerations, but, on the other hand, it can be very usefully employed as an auxiliary in the sterner aspects of life when it has, independently and for its own sake, already reached the standard it has attained in England to-day. There are plenty of artists and plenty of sanitarians; the two only need take counsel together, and sanitation may become as popular as Bridge, and eventually even find itself in a position to "snatch a grace beyond the reach of art." For the present we should be satisfied if it were able to snatch some of the graces within its reach.

### Notes on Current Topics.

#### Insects as Plague-Carriers.

THE discoveries of Manson and Ross with regard to the rôle of mosquitoes in disseminating malaria and filaria opened up a line of research in the propagation of disease that had up to that time been

almost unthought of. Their brilliant results have encouraged a host of workers all over the world, and it is possible that too much may be now attributed to insects and too little to other agencies unless absolute and demonstrative proof is demanded in every case of putative transmission. For instance, it has been somewhat hastily assumed that as the rat is known to suffer from plague, and is also known to be infested with fleas, these fleas are very likely the mediate agents of plague-transference from rat to man. A paper was read at the September meeting of the Manilla Medical Society by Maximilian Herzog, of the Government Laboratory in the Philippines relating the results of his attempts to fix the responsibility of these insects in the matter. His first experiments were directed to ascertaining whether fleas from rats would bite man, and after a hundred attempts to induce them to feed on his own hand he came to the conclusion that the fleas that live on rats in Manilla will not bite man. Then he tried to see if fleas fed on plague-infected rats would infect guinea-pigs with the disease. The guinea-pig had part of their backs shaved and infected fleas applied, but in no case could he obtain transmission of plague by this means. Herzog next endeavoured to discover if head-lice could act as carriers of contagion, and finding some alive on a plague patient who had died, he was able, by grinding them up and inoculating broth tubes with the resulting mass, to isolate plague bacilli in pure culture from the culture that ensued. His final opinion was that fleas were only remotely responsible for transmitting plague, if they were responsible at all. There appears, however, to be more than one variety of rat-flea, and some of the rarer kinds do bite man, but, on the whole, it must be conceded that work such as that of Herzog suggests a possible doubt as to whether some tropical enthusiasts may not have been somewhat inclined to jump at conclusions instead of laboriously verifying every step on the way. At the same time it is only right to add that the earlier experiments on the infection of healthy rats from their plague-infected fellows in adjoining cages appeared convincing as to the agency of fleas as carriers, to say nothing of the cases in which coolies contracted the plague from handling dead rats. Fortunately, in any case, prevention consists in killing the rats which act as hosts alike to fleas and to lice.

#### Vitality of Germs in Water.

WHILE it has long been known that water, even apparently pure, may act as the carrier of disease germs, it has generally been thought that their vitality gradually decreased with time, and consequently that the danger from an infected water was merely temporary in character. It was stated that though pathogenic germs continued to live for a short time in pure water, yet they tended to multiply but little, if at all. Many observations had been made which seemed to give a solid basis to this belief. For instance, Bolton

was led to conclude that the typhoid bacillus requires a considerable quantity of nitrogenous material to render water habitable, and that in ordinary tap water its limit of life is about seven days. In investigations by Karlinsky on the anthrax bacillus and the cholera vibrio very similar conclusions were reached. While some observers maintained that the lack of nutriment was the principal cause of the disappearance of pathogenic bacteria, others thought that they succumbed in the struggle with the more hardy non-pathogenic organisms. Recent experiments by Konradi seem to show, however, that in regard to these points current opinion is in the wrong. He has found that instead of dying out in tap water, certain pathogenic bacteria—typhoid bacillus, anthrax bacillus, and staphylococcus aureus—live for a long time, finally killing out all the ordinary water organisms. Thus, in the case of typhoid bacillus, a pure culture resulted in about two months, of anthrax in half that time. The typhoid bacillus lived in tap water at room temperature for 499 days. The practical lesson to be learnt from Konradi's experiments is that when water is once infected it retains its dangerous properties for much longer than has hitherto been supposed.

#### Chemists and Prescribing.

THE attitude of the best class of chemists towards the question of "counter-prescribing" is always more or less apologetic. It is admitted that prescribing does not fall within the legitimate sphere of work of the chemist, but there generally goes with this admission an attempt to show that there is a certain amount of unavoidable prescribing which falls into a chemist's business, and is said to be beneficial to the public. Some of the arguments brought forward by Mr. F. Truman, in a paper read recently to his fellow-chemists at Richmond in support of this thesis, strike us as worthy of comment. In minor ailments he thinks it is not only necessary for the business of the chemist, but for the good of the public, that the chemist should be able to prescribe suitable remedies. Curiously enough, he instances warts as one of these minor ailments which naturally fall to the chemist for treatment. This is rather an unfortunate example, for in the very same number of our contemporary (a) in which we read Mr. Truman's remarks, we find a report of an action against a chemist for injuries to a boy's hand by treating it with nitric acid for warts. Mr. Truman holds, too, that were it not for the treatment by chemists many cases would remain untreated at all until too late. This is possible, but there are probably far more cases where the treatment given by a chemist—in no true sense medical treatment at all—encourages a patient or his friend to do without medical assistance till it is too late for it to be of service. The same number of our contemporary draws attention to a coroner's remarks on this very point. We are, however,

(a) *Pharm. Journ.*, October 22nd, 1904.

quite ready to believe Mr. Truman when he says that the chemist, more frequently than is credited, prescribes a doctor.

#### Sterile Water Anaesthesia.

GREAT as has been the boon conferred on surgical patients by the discovery of general anaesthetics, it would be folly to assert that any anaesthetic yet known is free from drawbacks. They all have their disadvantages and dangers, and till the ideal anaesthetic is found, several of the methods in use at present will each have its appropriate sphere. Gant, the professor of rectal surgery in the New York Post-Graduate School, has just published a third contribution in eighteen months advocating the use of sterile water as a local anaesthetic. He claims that it is safe and trustworthy, and he states that he has adopted it only after trying cocaine and various other agents, which were liable either to produce toxic effects or to be followed by post-operative pain or hæmorrhage. The great point to be observed in using sterile water is to produce distension of the tissues until they become anæmic. To do this no large quantity of water is needed, ten minims to half a drachm being all that is required for small, and a half to four drachms for more extensive operations. An ordinary hypodermic needle is sufficient in the way of apparatus, and though the first injection may cause a little stinging this soon passes off, and the injections can be continued. Effective local anaesthesia is rapidly produced, and no unpleasant complications or sequelæ have followed in his 320 cases in which water injections have been used. Gant claims that he is now able to do in his office scores of operations on patients who would otherwise have had to leave their work for some time and go into hospital. As most of his operations have been in connection with rectal diseases, we think his evidence is particularly significant, as there are no more tender spots than the rectum and the margin of the anus when diseased. Piles, internal and external, fistula, fissure, and prolapsus recti have all been dealt with under simple water distension. Besides these, Gant has done a good variety of other operations, including an exploratory laparotomy, by the same plan. He does not consider that his method is likely to supersede the use of general anaesthetics for all ordinary surgical work, but for small operations he is convinced that no method can touch it, and he warmly recommends surgeons to try it.

#### Surgeon-General Evatt on Irish Medical Schools.

WE have had occasion in the past to differ with Surgeon-General Evatt, the special commissioner of the Irish Medical Association, when he informed the public at large that there was no mechanism in Ireland by which medical practitioners could obtain information on practical points connected with their profession, and we must now again differ with him in respect of his most uncalled-for attack on the Irish Medical schools. After a

(a) *Med. Record*, October 29th, 1904.

public dinner given in his honour last week in Roscommon, Surgeon-General Evatt spoke as follows :—

"They had no idea of the energy and force of English medical education. There they had plenty of money and a string of universities. The position of the Irish schools on the other hand called for the most earnest inquiry. In England and Scotland it was recognised that the training of a doctor demanded money and energy. Oxford had wakened up, and all England was waking up, re-acting against the Irish doctors, whose chances of getting employment in the public service were greatly injured by the want of fuller training and teaching in the Irish schools. In Ireland they wanted efficiency in every branch of the medical service. The doctor ought to be the teacher of humanity in the ways that lead to the betterment of humanity. But for this they required men of energetic and carefully trained character. At the present time the Irish medical schools are hardly mentioned, because they do not take part in research work."

May we ask Surgeon-General Evatt his authority for these statements, which appear to us to constitute a libel on the Irish medical schools? His indictment is all the more dangerous in that it is indefinite and vague. Does he mean to suggest that the Oxford medical school is superior to the Irish schools? Where is it that the Irish schools are never mentioned? It can hardly be where their graduates have gained distinctions, and if it is in places where they have not done so that "we never mention her, her name is never heard," it is not a matter of particular importance, for there are few such places. We notice that Surgeon-General Evatt has been addressing the students of these same Irish medical schools during the past week. Did he when doing so tell them his opinion of their teachers? If he did not do so, why did he not? If the creation of dissatisfaction is the surest way of effecting reform, surely it would be better to create such dissatisfaction at the centre rather than in a country town, where there are none to answer.

#### Twin Spirits.

THERE is not much to be said in favour of the public exhibition of human freaks and monstrosities, but while human nature likes to be surprised and horrified at the same time there will always be showmen ready to cater for this morbid taste. Since the Siamese twins shocked and delighted the British public a good many years ago, there have been many rivals for their fame, but none who have quite attained it. Two—or perhaps we should rather say one—bold candidates have entered the lists in the shape of the Bohemian twins, young ladies of prepossessing appearance joined to each other at the hips. They are twenty years old and not in the least alike, whilst in order to walk they have to pass their arms round each others' waists. An interesting and curious medico-legal question has arisen in connection with their journey to England; and as there appears to be no possible final solution to the problem, it will pro-

bably commend itself warmly to anthropologists, ante-natal pathologists, and counsel learned in law. The point is this: are the twins entitled to travel with one railway ticket? As a practical aid to the discussion, it may be stated that the German railway officials insisted on two tickets being taken, the Belgian authorities were content with one, whilst our own South-Eastern was ungallant enough to follow the Teutonic lead. To psychologists the question of duality or identity of the units that compose the twins should appeal with special attractiveness, and Mr. Rider Haggard's dog will now have to take a back seat, as the question of the hour, with those who are wrapped up in matters concerning thought-transference and telepathy. For ourselves, we only venture to express the hope that the young ladies are good friends; a quarrel leading to mutual estrangement opens up awkward possibilities.

#### The Science Schools in Trinity College, Dublin.

It will be remembered that some eighteen months ago Lord Iveagh made the munificent offer to supply funds for the erection of buildings as schools of science in Trinity College, provided funds for their up-keep were forthcoming from other sources within three years. It was calculated that a sum of £34,000 was necessary for building purposes, and that £78,000, invested at 3½ per cent., would be required for up-keep. For this £78,000 appeal was made to the public, and particularly to graduates of the University. It can hardly be said that the response has been gratifying. Those immediately interested in the College—Fellows and Professors—have contributed generously to the fund, but the sum received from the body of graduates in general is not what might have been expected. Up to the present about sixteen thousand pounds has been received, and this being sufficient for the maintenance of a physical laboratory, the building of the latter is about to be undertaken. We understand that the administration of the fund is to be in the hands of trustees quite independent of the Board of Trinity College, so that those who disapprove of the present oligarchical method of governing the College have no excuse on that ground for refusing to contribute. We are sure that there are many medical graduates of Dublin who will be glad to take the present opportunity of showing their love for "Old Trinity," and we have pleasure in bringing the appeal to their notice.

#### Militant Antivaccinists.

AMONG the minor troubles of the central government in this country the chronic difficulty with the antivaccinists is not the least. But bold and recalcitrant as they are, the antivaccinists confine their methods of warfare with the constituted authorities to the legitimate ones of public meetings and pamphleteering—with an occasional appearance in the law-courts. Not so, however, their *compères* in Brazil. The Congress of that country recently passed a law to enforce compulsory

vaccination, and a commission was appointed to draft the regulations required to administer the enactment. There was considerable public excitement in Rio de Janeiro at the time over the law, which was opposed to popular prejudice, and the premature publication of the regulations set the tinder aflame. In South American States the populace have a very practical way of showing their opinions on matters of public interest, and a riot which almost attained the dignity of a revolution was promptly organised. The Ministry of Industry, when the commission was sitting, was surrounded by the mob, and so threatening was its attitude that the troops were called out and a free fight began. The water-mains were cut the street-lamps destroyed, the trams set on fire, and the telephone wires cut. The rioting continued in spite of repeated charges by the troops, and when night fell it was found that seven persons had been killed and thirty wounded. The next day the disturbances were renewed, but fortunately the authorities were able to get wind of the movements of the ringleaders, and have them arrested. The riot was then suppressed, but not until quite an alarming list of casualties had occurred. After reading of these disturbances we are glad to think that our own antivaccinists, at any rate, employ only hard words in their controversies. And hard words break no bones.

#### Public Libraries and Infectious Diseases.

THE statement so often circulated in the lay press that free libraries spread infectious disease far and wide has created a perennial flutter among those literary dove-cotes. Regarded simply as a place where all sorts and conditions of men, women, and children congregate for the purpose of satisfying the wants of the mind, a process which necessitates touching the same object successively by scores of ungloved and, in many cases, unwashed hands, there is every reason why a public library should be an unfailling source of infectious disease. We have not seen any recently recorded instance of a contagious malady contracted by a visit to a reading-room, but in the event of a person in the desquamating stage of scarlet fever handling a magazine and scattering epidemic scales around him while so occupied it is conceivable that the periodical in question might become a source of infection to others. This is not, however, the fault of the library. Other public buildings are daily exposed to the same risk. The majority of the municipal authorities are now so fully alive to the dangers incurred by spitting, wetting the fingers before turning over the pages of a book or newspaper, in view of the omnipresence of the tubercle bacillus, that in many localities notices prohibitory of such practices are posted up in conspicuous places in the interior of the buildings. The only improvement that might, perhaps, be suggested with a view of further diminishing the risk of infection is the substitution of washable covers for magazines, &c., instead of the leather ones now in use. With regard to the question of infection from books taken home it is

gratifying to note that an inquiry instituted into the subject a few years ago as a result of circularising the medical officers of health in the principal towns possessing public libraries showed that not a single case of infectious disease could be definitely traced to this source.

#### Teaching of Hygiene in Primary Schools.

IN connection with the movement for the teaching of hygiene in primary schools, an influential deputation waited the other day on Dr. Starkie, the Resident Commissioner of National Education in Ireland. Sir William Thomson was the principal spokesman, and he was accompanied by the respective Presidents of the Royal Colleges of Physicians and Surgeons, the Academy of Medicine, and the Leinster Division of the British Medical Association, and other gentlemen. It was strongly pressed on Dr. Starkie that the teaching of hygiene and temperance should be made compulsory in the primary schools throughout the country, and that greater care should be taken to keep school buildings in proper sanitary condition. It was freely admitted by the Resident Commissioner that the rules of the Board as to the sanitary care of school buildings had been quite neglected in the past, and he quoted instances of scandalous mismanagement in this respect. Steps are being taken, however, to stop the grant to any school which shall in future be reported by the Board's inspectors as improperly kept as regards sanitary arrangements. With respect to the teaching of hygiene, Dr. Starkie bound himself to urge on his colleagues the advisability of including it in the new programme of studies as a compulsory subject. The result of the deputation is, on the whole, satisfactory, and it is hoped that before long every child in elementary schools in Ireland will learn something of the value of fresh air and cleanliness, and of the proper care of the human body.

#### Health and Statistics of Ireland.

IT is difficult to pick any crumbs of comfort out of the latest Quarterly Return from Charlemont House. Although the state of the country is good as regards prevalence of disease, yet the birth-rate is low in proportion to the death-rate, and the marriage-rate remains almost stationary. The emigration figures still show an alarming increase, not merely relatively to the estimated population, but in absolute numbers. Thus, the number of emigrants who left Irish shores during the months of July, August and September was 11,784, of whom nearly two-thirds were females. This total is 590 more than in the corresponding quarter of last year, and 1,075 above the average for the third quarter of the past ten years. Compared to the vital rates of England during the last quarter, the Irish birth-rate is 23.3 per 1,000 to 28.1 in England, while the death-rate approaches as close at 14.8 per 1,000 to 15.8 per 1,000. These figures depend in Ireland on the fact that it is the young adults who emigrate at the very time when they should be adding to the birth-rate. The mortality from infectious diseases is somewhat

below the average. Small-pox has appeared in sixteen or more centres during the quarter, and four deaths resulted. Measles had caused less trouble than in previous years, but whooping-cough of a severe type has been more prevalent than usual. Enteric fever has been less prevalent than is usual in the September quarter, though in Belfast it is responsible for thirty-one deaths.

#### Hats or No Hats?

SOME of the lay papers in New York have recently been discussing the question of the effect of hats upon the health. It appears that it was more or less fashionable this year in America to go with the head uncovered, and, as is natural, the hygienic advantages of the custom are being pointed out. It is stated, fairly enough, that the presence of a hat deprives the head of the healthy influences of the light and air, both of which are probably efficacious in maintaining a proper growth of hair. Further, there can be no doubt that a hard hat, such as the ordinary silk or felt hat, encourages the growth of bacteria about the hair by keeping it bathed in a warm, moist atmosphere. Objectors urge that to uncover the head may bring on neuralgia, rheumatism, and other diseases, but this is only liable to occur when one is suddenly exposed to unaccustomed chill. Patients in open-air sanatoria rarely wear head covering, and they rapidly become hardened against the ill-effects supposed to be due to sudden changes of temperature. There is no doubt, of course, that hats may be necessary for protection against the sun, but this, again, is only true where one is exposed to a degree of heat to which, individually or racially, he is unaccustomed. A native of the tropics goes bareheaded with safety where a European would infallibly suffer from heat-stroke. While "hatlessness" in fashionable society is at present little more than a fad, yet it is, on the whole, a healthy one, and we welcome it as part of the same rational view of costume which has rendered light and comfortable head-gear so much in vogue in England during the past few summers.

#### X-Ray Operator as Medical Witness.

THE new science of radiography has given birth to a fresh order of unqualified practice. Persons who hold no medical qualification pose as authorities on dislocation, fractures, and other injuries, not to mention bone diseases, lupus, cancer, rodent ulcer, and conditions open to treatment by the focus-tube. To a great extent the medical profession has itself to thank for having opened the door to this particular kind of competition. From the outset of this new branch of diagnosis we have insisted that medical men should send their cases to properly qualified medical radiographers and not to instrument makers and photographers and other unqualified persons who buy an apparatus and pose as medical advisers. The greatest blame we attach unhesitatingly to hospitals that employ non-medical radiographers. The evil likely to result in the creation of a kind of

hybrid medical practitioner was a week or two since illustrated at a Deptford inquest held upon the body of a child that died under chloroform administered for the purpose of taking a radiogram. Mr. Vezey, the non-medical superintendent of the X-Ray department of the Millar Hospital, was asked by the Coroner whether he thought the rays used on that occasion caused an irritation and affected the child's heart. Instead of referring so highly crucial and technical a question to a medical man, the witness, according to a report in the *Daily Chronicle*, expressed a view that the heart would not be so affected, but that beyond a doubt the X-rays would produce a painful disease if the use extended over several years. Mr. Vezey is well known as the treasurer of the Röntgen Society, and also as an amiable and unassuming student of scientific matters. We venture to think, however, that he is entirely out of place as a witness to medical questions of an extremely complicated nature. The attitude of the Coroner towards his evidence absolutely endorses our view as to the danger likely to arise from the interference of unqualified persons in things that are obviously purely medical.

#### The Wellcome Historical Exhibition.

THE proposed Historical Medical Exhibition has been postponed to a later date than that originally intended. The following announcement to that effect has been received from Mr. Henry S. Wellcome:—

"The response to the announcement of the proposed Historical Medical Exhibition has been beyond my expectations, and this, together with the many valuable suggestions received from leading members of the profession and the trade, at home and abroad, has prompted me to considerably widen its scope. The extent of the work involved renders it impossible to fix a definite date for the exhibition until a later period, announcement of which will be duly made. Although in one sense I regret this delay, it will, on the other hand, enable me to make the exhibit more comprehensive and complete, and to include many objects of exceptional interest that have been promised from different quarters of the globe."

The original discovery of the virtues of many therapeutic substances is surrounded with great interest, and we understand that Mr. Wellcome has given a good deal of attention to that branch of investigation. The collection of a large number of objects of special medical virtue cannot fail to be of value, especially as the bulk of the exhibits will be lent by medical men. The exhibition is meant not for the public but for the profession, and is intended to commemorate the completion of the first quarter of a century's existence of the firm of Burroughs, Wellcome and Co.

#### Action Against Sir Patrick Heron Watson.

THE decision of the second division in Sir Heron Watson's appeal against Lord Kincairney's interlocutor approving of the issues for the trial was given on the 18th inst., and was partially favourable to the appellant. The Court, by a majority of three,

to one, disallowed the first issue—that as to breach of confidentiality in disclosure, during precognition, to a law agent of facts concerning the pursuer. The second issue was allowed—whether the defender stated to the law agent and counsel that the pursuer was bent on inducing premature labour so as to free her from any permanent reminder of her marriage. The case, it may be remembered, arose out of evidence given by Sir Patrick Watson in an action for separation and aliment, the pursuer in this action failing in her case, and subsequently suing Sir Heron Watson on account of evidence given by him in behalf of her husband. Lord Young, who dissented from the remaining judges, thought that there was no relevant case whatever for sending to a jury against Sir Patrick Heron Watson, and that it was only just and fair to state that, so far as his opinion went, nothing which he was alleged to have done or said was at all improper or discreditable to him or any member of his profession. The case involved a principle of great importance, namely, the inviolability of knowledge gained of a patient's affairs. In this instance Sir Patrick Watson was consulted by a wife who was bringing an action for separation against her husband. Sir Patrick gave evidence for the husband, and stated that the wife on the occasion of her visit requested him to perform a certain operation. For this alleged breach of professional secrecy both the wife and her father brought actions against Sir Patrick, claiming £2,500 each damages. The part of the action remaining to be settled is that his statements as to the operation were falsely and calumniously made.

#### PERSONAL.

THE KING has sent the following reply to a letter announcing the death of Dr. Vintras, the late physician to the French Hospital in London:—"Sandringham, November 11th, 1904. Sir,—I have had the honour of submitting your letter to the King, and I am commanded to inform you, in reply, that his Majesty regrets to hear of the loss which the hospital has suffered by the death of Doctor Achille Vintras. I am, Sir, your obedient servant, KNOLLYS. The Secretary, French Hospital in London."

MR. ANTHONY BOWLBY, C.M.G., F.R.C.S., has been appointed to the post of Surgeon to the Household by his Majesty the King, a post rendered vacant by the recent lamented death of Mr. Herbert Allingham.

DR. MITCHELL BRUCE, who has been connected with Charing Cross Hospital and Medical School for the last thirty years, has been elected consulting physician to the hospital on his retirement from the active staff.

DR. J. S. COLLIER, Assistant Physician to the National Hospital, Queen Square, and Dr. E. I. Sprigge, Assistant Physician to the Chest Hospital, Victoria Park, and the Victoria Hospital for Children, have been recently appointed Assistant Physicians to St. George's Hospital.

It is probable that the proposed American memorial to Professor Osler will take the form of a great medical and library building to be erected in Baltimore.

THE inaugural address of the Medical Women's Society, Edinburgh, was given on Friday, November 11th, in the hall of the University Union, by Dr. George A. Gibson, on "The Uses of a Debating Society."

THE KING has been pleased, on the recommendation of the Secretary for Scotland, to appoint Dr. W. Leslie Mackenzie to be medical member of the Local Government Board for Scotland, in room of Dr. Russell, deceased.

THE second biennial dinner of the past and present resident assistants of the Victoria Infirmary was held in Glasgow, on November 11th, under the presidency of Dr. William Dove Macfarlane, Jun., of Busby.

MR. JOHN TWEEDY, President of the Royal College of Surgeons of England, will unveil the memorial window to the late Mr. W. Cadge in Norwich Cathedral on Tuesday next, when a short service will be conducted by the Dean.

IT is interesting to learn that the widow of the late Professor Finsen has been accorded a pension of 3,600 kroner yearly by the unanimous vote of the Danish Parliament on the proposition of the Cultus Minister.

DR. W. F. DEARDEN, a prominent citizen of Manchester, has been placed on the Commission of the Peace of that city. Another medical man has been accorded a similar distinction in the East Riding of Yorkshire in the person of Dr. J. J. Jefferson, of Market Weighton.

DR. WHITELEGGE, C.B., delivered a most interesting inaugural address to the Epidemiological Society on November 18th, upon the subject of the epidemiological aspects of industrial diseases.

DR. E. H. TWEEDY, Senior Medical Officer of the Gold Coast Colony, acts as Cantonment Magistrate of Kumasi in place of Captain T. A. Pamplin Green, who is acting as Commissioner for the North-Western District of Ashanti.

MR. JOHN IRONSIDE, of the Medical Department of the Orange River Colony, has been promoted to the position of Secretary and Registrar of the Medical and Pharmacy Council of that Colony.

DR. J. H. BAIN has been appointed District Surgeon of Richmond, Cape Colony, in place of Dr. David Traill, who has resigned, and Dr. Ludwig Schloss becomes District Surgeon of Bredasdorp.

## Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

#### SCOTLAND.

AGE LIMIT FOR THE STAFF OF THE ROYAL INFIRMARY, EDINBURGH.—Contrary to the general anticipation, the Court of Contributors of the Royal Infirmary last Monday refused to endorse the report of the special committee on this subject, and passed a resolution that an age limit of sixty-five be adopted for all physicians and surgeons, including University Professors. The resolution was moved by Mr. Charles Ritchie, and seconded by Dr. P. H. Maclaren, the members of the committee who dissented from the findings of the majority, as mentioned in this column last week. The Lord Provost, who presided over the meeting of contributors, said he earnestly hoped that the decision of the meeting would make for the benefit of the institution. The managers would loyally carry it out. It is not yet known whether the rule will be applied to those presently holding office as full physicians and surgeons, several of whom have passed the age of sixty-five.

QUATERCENTENARY OF THE ROYAL COLLEGE OF SURGEONS, EDINBURGH.—This ancient Corporation completes the four-hundredth year of its existence in 1905, and for some time back the officials have been preparing for its celebration. The function has been arranged for the 20th and 21st July, when, among other events, a large number of distinguished



members of the profession, both at home and abroad, will be admitted as honorary Fellows. On Thursday the 20th, there is to be divine service in St. Giles Cathedral, followed by a luncheon and an address from the president; thereafter the honorary Fellowships will be granted, and there will be a reception. On the 21st there will be visits to museums and other institutions of medical interest, a garden party, a dinner, and a reception. The sister college and the Corporation of Edinburgh, will also take part in entertaining the College of Surgeons and its guests.

#### BELFAST.

**THE SMALL-POX OUTBREAK.**—During the past week there have been five more cases of small-pox in Belfast, all removed as soon as discovered to the hospital at Purdysburn. Of these five, one is a severe case in an unvaccinated child of eight years, while the other four are all modified by vaccination.

**ULSTER MEDICAL SOCIETY.**—The first of a series of social evenings for the members of the Ulster Medical Society was held in the Medical Institute, Belfast, on Thursday evening, the 17th inst. The President of the Society, Dr. William Calwell, entertained the members and some other medical men to light refreshments, and the social amenities offered by the Institute were enjoyed till a late hour. The Council of the Society intend to issue invitations to a similar evening next month, the idea being to bring the members of the profession, not only in Belfast, but in the surrounding districts, into more intimate social relationship in their leisure time. The Institute forms a common meeting ground for men from all parts and in all classes of work, practice or teaching, and such evenings cannot fail to promote friendship among them.

### Correspondence.

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

#### THE DIMINISHING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the letters which you did me the honour of inserting in your pages during the discussion of the above-named subject some weeks ago, I insisted on two main facts—first, that the diminishing birth-rate is due mainly to the practice of preventing conception by artificial means, which already prevails among large sections of every class of the people; and, secondly, that the restriction of the number of children was, in the majority of cases, not prompted by motives of prudence, but was rather the outcome of a narrow form of anti-social egoism which is willing to give up everything in the pursuit of ease, pleasure, and amusement, and looks upon duty, toil, and self-sacrifice as evils at all costs to be avoided. I pointed to France as a living object-lesson in these matters, and ventured to declare that the nations which should follow her example to its logical conclusion were doomed, as she is unless she speedily mend her ways, to destruction. As a lover of my country and a believer in the mighty possibilities for good of a vast dominant Anglo-Saxon empire, I should have been gratified if my views could have been proved false; and I am not at all pleased now to find them receiving the strongest corroboration from what is evidently the highest authority. I refer to the author of a series of special articles on "Infantile Mortality," the last of which appeared in the *Times* of to-day (Wednesday, November 9th). The intrinsic quality of these articles, not excepting their literary style, stamps them as the work of a first-rate man—not an uncommon phenomenon among *Times*' contributors—and I feel a little flattered to find he expresses, although much more forcibly than I could have done, virtually the same conclusions that I had in my letters put forth. The articles deserve your attention, Sir, and that of all students of this truly important question—a question upon which the prosperity and the stability of the Empire rests beyond all others. I will quote only two passages from the last

article; for the facts and arguments upon which they are based the originals must be consulted. Probably they may be published in a permanent form later:—"Although fewer children are born in proportion to population, a larger number of them die soon after birth. What is the explanation of this grave state of things? It might possibly be explained by a general decline in physique, which renders women less capable of child-bearing, so that they have fewer children, and those whom they have are weaker. But the change has been much too rapid and general to permit of that hypothesis, which has no other evidence to support it. Moreover, physical incapacity is not the cause of the declining birth-rate. That is well known to be due to deliberate prevention, which is practised more extensively among the industrial classes than among those above them in the social scale."

"To sum up, the unnatural concurrence of a stationary or increasing infantile mortality with a falling birth-rate, which so seriously threatens the national vitality, finds its true explanation neither in external circumstances nor in the employment of women, but in the habits of the people. Throughout the scale, from mere thoughtlessness to actual murder, the same elements are seen to be at work and to tend, in varying degrees, towards repudiation of the duties of life and their subordination to ease, comfort, pleasure, and self-indulgence."

I am, Sir, yours truly,

A STUDENT OF SOCIOLOGY.

November 9th, 1904.

#### THE SPA TREATMENT OF ARTHRITIS DEFORMANS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read with great interest the article contained in this week's issue of THE MEDICAL PRESS AND CIRCULAR by Dr. Bowen-Davis on "The Spa Treatment of Arthritis Deformans." While agreeing with him in a great deal of what he says, I am nevertheless inclined to think that he attaches too little importance to the rôle played by rheumatism in its production. Seeing that rheumatism is now almost (if not, indeed, conclusively) proved to be of microbial origin, I would suggest that the various lesions of arthritis deformans, resembling as they do the joint changes observed in Charcot's disease, may be the result of inadequate nerve supply, due to the poisoning of nerve endings by the toxins elaborated in the system by Poynton's micrococcus.

It is noteworthy, as Dr. Bowen-Davis says, that these lesions should be so prone to manifest themselves at the climacteric period, and it may be as well to bear in mind in this connection that the nervous system is at that period of life undergoing profound changes, none the less important that they may not be accompanied by visible changes. From my experience of balneo-therapeutic measures in this class of case I am convinced that they hold out distinct chances of improvement if not of actual recovery.

A point in the history of these cases is worth noting, viz., that if careful inquiry be made a history of weakness long preceding the joint changes may be obtained. In fact, I feel that it is hardly going too far to utilise this symptom when complained of as a means of differentiating between arthritis deformans and chronic rheumatic arthritis. Perhaps Dr. Bowen-Davis may be able to corroborate this observation.

I am, Sir, yours truly,

ARTHUR G. BENNETT.

St. Ann's Hill, Cork, Nov. 18th, 1904.

### Special Articles.

#### REPORT ON SLEEPING SICKNESS IN THE CONGO.

THE members of the expedition despatched by the Liverpool School of Tropical Medicine have sent to the Committee a long report on their experiences

in the Congo. Dated from Stanley Falls, September 20, the report says:—

"The members of our expedition left Leopoldville on June 23, and reached Stanley Falls on September 15. One of the State's steamers, the *Roi des Belges*, was very kindly placed at our disposal by the Government, and we were thus enabled to make fairly complete observations on the spread and distribution of sleeping sickness along the Congo River from the 'Pool' to the 'Falls,' a distance of nearly 1,000 miles. A disease whose nature had been previously unrecognised occurred among the State's cattle at Coquilhatville, Nouvelle Anvers, and Romee. It was investigated, and its pathogenic agent shown to be a trypanosome, whose species is as yet undetermined. It was considered advisable to communicate the results of this work directly to the Governor-General at Boma, in order that immediate measures might be taken against the disease. It is no exaggeration to say that sleeping sickness is a terrible scourge among, especially, the riverine tribes—who, by the way, are generally totally distinct from the tribes living frequently only ten to thirty minutes' walk from the river banks. From Leopoldville to Bumba cases of sleeping sickness were present in practically every town visited, and the percentage of trypanosome-infected individuals among the general population was high. After Basoko and up the Falls only imported cases (with two exceptions) of sleeping sickness were seen in a few of the towns, and no trypanosomes were found in the general population. The inland towns which were examined, at M'Swata, Tschumbiri, Lisala, and Bumba, showed a much smaller percentage of trypanosome infections than did the corresponding riverine towns, and it was exceedingly rare to see a case of sleeping sickness.

"From our observations and from information which we have collected, it is very apparent that sleeping sickness has spread in the Congo in recent years along the lines of communication—*i.e.*, along the rivers. The spread of the disease has been much assisted by the practice of taking large bodies of natives, soldiers, and labourers, from one part of the Free State to another. For instance, four natives were chosen for gland puncture, because of large lymphatics, from 77 persons examined at Yalembe. Two of these were found to be infected with trypanosomes. Both seemed in robust health. Three years previously one had returned from a year's work as a labourer at Bolobo, where there is much sleeping sickness. The other had spent three years as a labourer on board a steamer plying to infected districts. A third man, suspected of sleeping sickness, was examined and trypanosomes found. He had been ill for two months, and had returned one and a quarter years before from a year's work at Bolobo. We are told that there was a well-marked case of sleeping sickness in the village (absent at the time of our visit) who had also been a Bolobo workman. Yalembe, situated on the river bank, some little distance above Basoko, is in an uninfected area, and the latter two cases are the only instances of sleeping sickness known there. It is only a few months since the transportation of cases of sleeping sickness on State steamers has been forbidden. Individuals previously affected had been allowed to return to die in their, perhaps, uninfected villages. Declared cases of sleeping sickness are easily recognised; but, as we showed in the Gambia, *trypanosoma gambiense* may be present in the blood for months, even years, and the patient remain in apparently perfect health. The importance of the early recognition of such cases is obvious, and it has long been one of our chief aims to devise some easy and fairly accurate method of detecting the presence of trypanosomes. We believe that in 'cervical gland palpation' we have now an excellent clinical method of detecting an infected person. When many of the cervical glands have been enlarged to above 1.5 by 1 cm., other causes being absent, trypanosomes have generally been found in the drop of fluid obtained by aspirating a gland with a hypodermic syringe. As a rule simultaneous examination

of the blood had given a negative result. Cervical glands have been chosen because the native's femoral and inguinal, and, to a less extent, his axillary glands, are usually enlarged. In uninfected areas the cervical glands very rarely reach the size indicated above, and in none of the glands punctured in non-infected areas have trypanosomes been found. Our work in this direction is far from complete, but we believe that it tends to indicate that no intending labourer or recruit, coming from an area in which sleeping sickness exists, should be accepted if he is found on examination, other causes being absent, to have fairly numerous, moderately enlarged cervical glands. The tsetse fly was incessantly present from Stanley Pool to Basoko. These flies were very numerous among the myriads of islands with which the middle Congo is strewn, and frequently came on board our steamer while we were in mid-stream and distant 300 or 500 yards from land. After Basoko was passed there were very few flies, and just after we left the mouth of the Lomami river the last one was seen on the steamer. Although the natives of the towns at which we stopped above Basoko recognised the fly, none were found in the neighbouring bush. There is certainly a marked reduction in the number of tsetse flies above Basoko, and it is possible that there may be stretches of river where none occur. It is an interesting coincidence that where there were many tsetses there was much sleeping sickness. Where these flies were scanty, cases were rarely seen. The common species of tsetse on the middle Congo is *Glossina palpalis*. At Menseme and Nouvelle Anvers this fly frequented the houses of Europeans."

#### METROPOLITAN ASYLUMS BOARD.

AN ordinary meeting of the managers of the Metropolitan Asylum District was held at the offices on the Embankment, Mr. A. C. Scovell presiding. A letter was read from the London County Council stating that the Public Health Committee were desirous of discussing with representatives of the Board "the subject of facilities to medical practitioners and students for acquiring experience of small-pox," and asking the Board to appoint representatives to the conference. The communication was referred to the Hospitals Committee, with power to appoint representatives. The Works Committee reported that the total cost of the erection and fitting up of the Millfield Homes (where accommodation is provided for 100 patients), including the cost of the site, but exclusive of that of furniture, was £25,084, which works out at nearly £251 per bed. The original contract amount was £17,228, but certain unforeseen works were found necessary when the buildings were in progress, which involved additional expenditure. The same committee reported that the total cost on completion of the White Oak School was £119,707, or £5,986 less than the anticipated expenditure of £125,694, for which the Local Government Board issued their order on March 23rd, 1901. On the recommendation of the Hospitals Committee, it was resolved to affix the seal of the Board to certain agreements with the Royal Colleges of Physicians and Surgeons consequent on the decision of the Board to take over from those colleges the work of preparation of anti-toxin serum, which the managers, with the approval of the Local Government Board, have decided to undertake for one year from January 1st next. Dr. G. E. Cartwright Wood was appointed for one year from January 1st next to have charge of the work at his present salary of £400 for the year, with duties, in addition to the preparation of anti-toxin, of general bacteriological work for the Board as might be directed; and Professor G. Sims Woodhead was appointed for the same period as adviser in connection with the Board's work of the preparation of anti-toxin serum at a fee of 100 guineas. Mr. T. Duncombe Mann, the clerk, presented returns showing that there was only one small-pox patient under treatment, and that there had been no admissions to, or discharges from, the Board's small-pox institutions during the fortnight ended Thursday last.

## Obituary.

W. C. NEVILLE, M.D.DUB., F.R.C.P.I.

It is with more than ordinary regret we record the death of Dr. William C. Neville, of Dublin, who died on the 15th inst. After a distinguished course in Trinity College he took his medical degrees in 1878, and soon devoted himself to the obstetric branch of the profession. In this line he had already reached a high place both as a teacher in the old Carmichael School and in practice, when, unfortunately, his health gave way, and he had for some years to retire from practice. During his retirement he gave much time to the study of pathology and bacteriology, with the result that when he resumed more active work a few years ago his opinion as a pathologist, particularly in gynaecological cases, was recognised as one of the best in Dublin. Under the mastership of Dr. Purefoy he was installed as Pathologist to the Rotunda Hospital, and the work he did there has been of the greatest value. In fact, at the time of his death his authority in the special branch of gynaecological pathology was second to none in the kingdom. His work, however, was done so modestly that few outside his own circle of acquaintances knew anything of it. Though ailing for some weeks, he was unaware that there was anything seriously wrong with him and he kept at work until eight days before his death. An acute attack of nephritis proved quickly fatal. A man of wide culture outside his specialty, an athlete of note in his younger days, he once captained the Irish Fifteen. Dr. Neville retained to middle life the freshness and honesty of youth. Of marked literary tastes, and with a literary gift of a very high order, it is unfortunate that circumstances forbade more generous contributions to the literature of science. His name is associated, however, with what is probably the most useful axis-traction midwifery forceps that has been devised. At the time that his health first broke down he had in preparation a work on obstetrics, which, alas! has never been carried to a conclusion; and again at the time of his death he was engaged in writing a contribution on puerperal septic infection to a similar work. He also had in contemplation the preparation of a manual on gynaecological pathology. Had Neville not succumbed in the first instance to the consequence of hard work and mental strain he would long ere this have reached the very topmost rank in his profession. There are many men who can claim pre-eminence in the practical side of the profession of medicine, there are many who have acquired a wide knowledge of theory and who at the same time have the power of placing their knowledge before their fellows; but there is no man with whose work we are familiar who unites the three qualities as did he. A man of absolute honesty and fearlessness of principle, withal of singular gentleness and tractability, with an indescribable charm of manner, Neville's memory will remain green among his friends when many who have figured more largely in the world of medicine have been forgotten.

## Laboratory Notes.

### NEW REMEDIES.

Messrs. PARKER, DAVIS AND COMPANY have sent us samples of the following three new specialties:—

1.—*Acetozone Inhalant* is a powerful germicide, deodorant and local anæsthetic. It is stated to contain 1 per cent. of acetozone dissolved in liquid petroleum, a colourless, odourless, liquid paraffin. The Inhalant is used as a spray from a nebuliser, after the nasal chamber has been thoroughly cleansed with an alkaline solution. The germicidal action takes place only after the acetozone has been hydrolysed by the moisture of the mucous membrane, and thus ensures the therapeutic application of the per-acids whilst these are in the nascent condition.

2.—*Adrenalin Inhalant* is a preparation consisting of a solution 1-1,000 of adrenalin chloride in an aromatic neutral oil base with 3 per cent. of chloroform.

It is an excellent application in inflammatory affections of the nose and throat, and is recommended as a soothing and antiseptic astringent in acute rhinitis or coryza. The best results are obtained by spraying it into the nasal passages from a nebuliser. Of great service in the treatment of hay fever and chronic nasal catarrh, and superior to many other astringent agents because of its bland nature in the treatment of pharyngitis, tonsillitis, and laryngitis with aphonia. Also used as a lubricant for urethral instruments, tending to reduce the turgescence of the mucus by its astringent action.

3.—*Adrenalin Ointment* is compounded of one thousand parts to one part of adrenalin chloride in a bland, unirritating, oleaginous base. It is adapted to the treatment of inflammatory conditions of the mucous membrane of the nose in coryza or rhinitis, hay fever and asthma. It is a useful application to inflamed surfaces such as external and internal hemorrhoids. Put up in collapsible tubes provided with an elongated tip, to facilitate introduction into the nose, urethra, and external ear, and by means of an ointment syringe within the rectum.

### ALLSOPPS LAGER BEER.

SIR A. CAMERON reports that his analysis of the lager beer manufactured by Messrs. Allsopp and Sons gave the following results:—100 parts by weight contain the following percentages: Water, 89.49; absolute alcohol, 4.34; malt sugar, 2.04; Dextrine, 3.34; albumen and albumenoids, 0.40; acids, calculated as acetic, 0.12; and mineral matter (ash), 0.27. It is free from excess of acid, from "preservatives," and from arsenic and other impurities which have sometimes been detected in ales. It is an excellent beverage, and one which persons who cannot drink heavier malt liquors will be likely to find digestible and wholesome. It is brewed on the continental low-fermentation system the fermentation rooms being kept at a uniform temperature all the year round by ammonia ice machines, whilst the method of manufacture in their new lager brewery at Burton-on-Trent is thoroughly up to date.

### Addresses on the Poor-Law Medical Service in Ireland.

DURING the past week Surgeon-General Evatt, who is on tour in Ireland under the auspices of the Irish Medical Association, addressed a series of meetings at the different medical schools in Dublin. The first meeting took place at the Royal College of Surgeons, and at it Sir Lambert Ormsby took the chair; the second meeting in Trinity College, Sir Charles Ball in the chair; and the third at the Catholic University Medical School, Dr. Anthony Roche in the chair. At all three meetings Surgeon-General Evatt's address was received with great enthusiasm. The question is, however, being asked, What is it all for, if the Irish Medical Association are about to abandon the Enniskillen programme, and to withdraw their demand for a minimum salary of £200 per annum? It is not the mere abandonment of the actual sum demanded as Enniskillen that we fear will work harm, so much as the sending abroad of an impression that the members have been beaten on one point and can therefore be also beaten on others.

### The Medical Graduates' College and Polyclinic.

THE sixth annual dinner of the Medical Graduates' College and Polyclinic will be held at the Treadero Restaurant, Piccadilly Circus, on Wednesday, December 7th, at 7.15 for 7.30 p.m., Dr. C. Theodore Williams in the chair. Ladies are admissible as guests. Dinner tickets, 7s. 6d. (exclusive of wine), can be obtained from Mr. Hayward Pinch, F.R.C.S., 42, Chenies Street, W.C., to whom all communications should be addressed.

### St. Louis Exhibition Awards.

BESIDES those already announced in connection with medicine and medical appliances, a gold medal has been awarded to the Jeyes' Sanitary Compounds Company for Cyllin and its preparations. Also to the Hutchinson Acoustic Company, a Gold Medal for the Massacon and Acousticon, as the best appliances known for the relief of deafness and instruction for the dumb.

## 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 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.

### IRISH POOR-LAW MEDICAL SERVICE.

Writing a letter of regret for inability to attend a lecture by Surgeon-General Evans, the Most Rev. Dr. Hoare, Bishop of Ardagh, expresses sympathy with the object of the meeting and with the intention of the Irish Medical Association, and says:—"It is quite wrong to expect professional men to discharge their onerous and responsible duties with credit to themselves and satisfaction to the public, unless a due sense of proportion in the remuneration of their professional services is observed by the people's representatives. No doubt the people are poor, and the demands upon them consequent upon the Local Government Act are well nigh oppressive, but there should be an amelioration of the status of the hardest worked man in existence—the Irish Dispensary and Workhouse Doctor."

**BUXTON (F.G.E.).**—If you will give a little more detail as to the exact current available from the main we should be pleased to advise you as to apparatus.

### THE VAGARIES OF MODERN LOCOMOTION.

LORD Baring's motor-car, which was sent to Winchester in haste last week to fetch Doctor Applebe and a nurse to Stratton Park, to attend on Lord Norbrook, ~~ran into~~ a milk-cart on the return journey. Dr. Applebe and the chauffeur were thrown out, the doctor sustaining a fracture of the left arm, and the chauffeur a dislocation of the shoulder.

**G. A. G. BROWN (Liverpool).**—If you are anxious to secure a resident patient the best course is to write for particulars to the Hon. Sec. Association Resident Patients, 18A Hanover St., London, W.

### A THERAPEUTICAL NOMENCLATURE.

We understand that the two new ships on order for the White Star Line are to be named in accordance with the traditional termination in "ic"—one the "Cathartic" specially recommended for a speedy passage, and the other the "Emetic," more particularly adapted for travellers who desire a quick return.

**MONOPLEGIA (Orkney).**—Whether the conditions be one of neuræmia or of hysteria, it would be wise to try the effect of a course of high-frequency electrical current. The good effect is not usually experienced until the eighth or tenth application. Go to a medical specialist.

## Meetings of the Societies, Lectures, &c.

THURSDAY, NOVEMBER 24th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. G. Henschell: Modern Intra-Gastric Methods in the Treatment of D. cases of the Stomach.

**POST-GRADUATE COLLEGE** (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. S. E. Harris: Cancer of the Rectum.

**SAMARITAN FEMALE HOSPITAL FOR WOMEN** (Marylebone Road, N.W.).—3 p.m. Dr. Roberts: Cases from the Wards.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture: Dr. F. N. Kelly: Practical Points in the Hygienic Treatment of the Respiratory Affections (illustrated by preparations). (Post-Graduate Course.)

**CHEARING CROSS HOSPITAL.**—3 p.m. Mr. Gibbs: Demonstrations of Surgical Cases. (Post-Graduate Course.)

**THE HOSPITAL FOR SICK CHILDREN** (Great Ormond Street, W.C.).—4 p.m. Lecture:—Mr. S. Collier: Peritoneal Infection in Childhood.

FRIDAY, NOVEMBER 25th.

**CLINICAL SOCIETY OF LONDON** (20 Hanover Square W.).—8.30 p.m. Papers:—Dr. C. E. Box: The Crises of Pustular and Bacterial Meningitis.—Dr. H. D. B. Weston: A Case of Unilateral Tuberculous Meningitis in which a Bulicous Eruption followed Lumbar Puncture.—Mr. E. M. Corner and Mr. L. S. Dodgson: Post-operative Acute Local Tuberculous Infection.—Mr. C. Wallace: A Series of Intussusceptions in Children.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chenies Street, W.C.).—4 p.m. Mr. M. Yearsley: Clinique. (Ear.)

**POST-GRADUATE COLLEGE** (West London Hospital, Hammersmith Road, W.).—5 p.m. Mr. Armour: Injuries to the Spine and Spinal Cord.

**NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC** (Queens Square, Bloomsbury, W.C.).—8.30 p.m. Dr. J. Taylor: Ophthalmoplegia in Diseases of the Nervous System.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture:—Mr. P. Brooks: Amblyopia, Congenital and Acquired.

MONDAY, NOVEMBER 29th.

**ODONTOLOGICAL SOCIETY OF GREAT BRITAIN** (20 Hanover Square, W.).—8 p.m. Papers by:—Mr. T. H. Kell-ock, M.D., M.A., F.R.C.S., on "Antinomycosis," Mr. E. Denison Pedley, F.R.C.S. Ed., M.R.C.S., L.D.S. Eng., on "The Relationship between Dental and other Diseases."

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital).—4.30 p.m. Lecture: Dr. Corner: Maula and Melanconcha.

## Vacancies.

**Bermondsey Parish.**—First Assistant Medical Officer. Salary £17 per annum, together with ration, washing, f. furnished apartments, and attendance. Applications to K. Pitts Fenton, Clerk, Guardians' office, 183, Tooley Street, S.E.

**Royal Surrey County Hospital, Guildford.**—Resident House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to the Hon. Secretary.

**Jersey General Dispensary and Infirmary.**—Resident Medical Officer. Salary £120 a year, with rooms, gas and attendance. Applications to Hon. Secretary, Infirmary, Jersey.

**Bracebridge Asylum, near Lincoln.**—Junior Assistant Medical Officer. Salary £125 per annum, with furnished apartments, &c. Applications to W. T. Sage Jun., Solicitor and Clerk to the Visiting Committee, 5 Back Street, Lincoln.

**Addenbrooke's Hospital, Cambridge.**—Secretary-Superintendent. Salary £250 per annum. Applications to the Secretary, 23 St. Andrew's Street, Cambridge.

**The Hospital for Sick Children, Great Ormond Street, London, W.C.**—Resident Medical Superintendent. Salary £115 per annum, with board and residence in the hospital and £5 washing allowance. Applications to James McKay, Acting Secretary, County Mayo Infirmary.—Assistant Surgeon, also to act as Compounder. Salary £140 per annum, with apartments, attendance, &c. Applications to Dr. M. O'Malley Knott, Resident Surgeon. (See advt.)

**Royal Hospital for Incurables, Dublin.**—Resident Medical Officer. Salary £120 per annum, with board &c. Applications to J. J. Thompson, Registrar. (See Advt.)

## Appointments.

**BREBLET, W. E., M.R.O.S., L.R.C.P.,** House Surgeon to the Women's and Children's Hospital, Leeds.

**LAURIE JAMES, M.B., C.M. Glasg.,** Medical Officer to the Smithstone Asylum and Poor House Greenock.

**LEE, E. H., M.D.,** Resident Physician Richmond, Whitworth and Bardwicks Hospitals, Dublin.

**RUTHERFORD, J. W., M.D.,** Resident Surgeon, Whitworth and Harwicke Hospitals, Dublin.

**ST. JOHN, WINSTAN T. A., M.B.C.S., L.R.C.P. Lond.,** Honorary Surgeon to the Derbyshire Hospital for Sick Children.

**TUMBER, H. STANLEY, M.B.C.S. Eng., L.R.C.P. Lond.,** Registrar to the Central London Ear and Throat Hospital.

## Births.

**WATSON.**—On Nov. 14th at 47 Mount Pleasant Road, Tunbridge Wells, the Wife of G. Trustram Watson, M.A., M.B., B.C., F.R.O.S., of a daughter.

## Marriages.

**BRYDEN-KETCHEN.**—On Nov. 17th, at All Saints' Eastmore Gardens, London, S.W., Charles Lumsdaine, son of the late Surgeon-Major J. L. Bryden, M.D. Bengal Medical Service, to Beryl Eme, younger daughter of Major-General L. Ketchen, late Royal Artillery, of 6 Nevern Mansions, London.

**LOMER-MESSUM.** On Nov. 16th at St. Stephens' Church, London, S.W., Capt. C. J. McIlreath Lomer, B.A. Hussars, second son of Cecil Wilson Lomer, Esq., late of Rosemore, Shirley, Haats, to Maude Antoinette, eldest daughter of Gordon Messum, M.D., of the Gables, Pretoria.

## Deaths.

**CHILD.**—On Nov. 18th, at Wei-hai-Wei, Cecil Edwin Criswick aged 29, surgeon R.N., H.M.S. Ocean, second son of the late Edwin Child, M.B.C.S. of New Malden.

**HORWOOD.**—On November 9th, at Coyton, Bournemouth, Sarah Elizabeth (Seia), the dearly loved wife of Dep. Surgeon-General Horwood (Ret.), A.M.D. aged 50.

**NEVILLE.**—On November 15th, at 70 Lower Mount Street, Dublin, Wm. Cox Neville, M.D., aged 49 years, second son of the late John Neville, C.E., County surveyor, co. Louth.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, NOVEMBER 30, 1904.

No. 22.

## Original Communications.

### COCAINISATION OF THE SPINAL CORD. (a)

By ROBERT JONES, F.R.C.S.,

Surgeon to the Royal Southern Hospital and the Liverpool Country Hospital for Children.

MR. PRESIDENT AND GENTLEMEN,—Spinal cocaineisation has been known among foreign surgeons as having distinct claims, yet very little is heard of it from our own people. It is because I believe that its employment is more often indicated than English surgeons seem to recognise that I venture to draw attention to two typical cases where its use proved of value.

A working man, æt. 30, was sent to me by Dr. Marsh, of Atherton. He had been a wilful, obstinate patient, who, in spite of every care on the part of his doctor, presented a malunited fracture of the lower third of the tibia and fibula. His foot was everted, and the lower fragments in addition were displaced backwards. I explained to him it was necessary to excise bone and wire fragments, and to this he at once consented. He was a big person, and as soon as he had taken two or three whiffs of chloroform he jumped off the table and scampered down the corridor and back to bed. Persuasive methods were unavailing, and Nature had so endowed him that we felt forcible methods had best be kept in abeyance. There was nothing left us but to dismiss him and to forget him. A fortnight later, his promises had been so alluring, we re-admitted him, and we underwent precisely the same experiences as before, and a second time he left the hospital. I explained to Dr. Marsh how impossible he was, but I promised to take him in a third time, and on this occasion determined to cocaineise his cerebro-spinal fluid. He submitted to this without protest. A fifth of a grain was injected between the third and fourth lumbar vertebræ, and in ten minutes all sensation left him to well above the umbilicus. He was an old poacher, and while I was operating he poured into the ears of Mr. Littler Jones anecdotes relating to his art. He exhibited no signs of pallor and nausea, and the only interest he took in the operation happened when I was chiselling through very hard callus—he then asked "what is that knocking?" He took a good meal when he went back to the ward, had no untoward symptom, and made an uneventful recovery.

The second case I present to you is that of a man of nearly sixty, who had always led an active

life, but had for some years been crippled by a disorganised tuberculous hip. I saw him with Dr. Warburton, and found his condition truly deplorable. He had fallen on his already diseased and painful joint. It was flexed to a right angle, tense, glazed, adducted, exquisitely sore. A foot-step on the floor, the closing of a door, a cough were followed by intense suffering. A splint he had always refused to wear. We removed him in a few days to a little ward in the hospital, where he arrived much exhausted and distressed. One then found that in addition to an abscess deep-seated, he had cavities in his lungs. The problem we put to ourselves was this—Are we justified in excising a hip, in an exhausted patient with a pulse of 130 and cavities in his lungs, so that should he survive the shock he might wear a splint with comfort and end his days comparatively free from pain? Our decision was made easy by the patient, who pleaded that death would be a grateful release from so much suffering. We decided to operate, and Mr. Alexander proceeded to administer chloroform. Only a few whiffs had been taken when the patient's face became blue, his pulse disappeared, and his extremities became cold. We thought he would die on the table, and he was hurriedly removed to the ward. The anæsthetic produced considerable shock, and for some days serious reaction occurred in the lungs. We decided on the next occasion to cocaineise the spine. His pulse was 140, and we sterilised very carefully the spine, using specially prepared hermetically sealed aseptic cocaine solution for injection. In from five to ten minutes his hip could be moved without pain, and he was carried into the theatre. A screen was placed in front of him, and the operation was proceeded with. Very rapidly a long incision was made, a large abscess of fœtid pus evacuated, the head of the femur removed, and the acetabulum scraped. When the femur was being sawn the patient said, "I know he is doing something to me now, for I feel my body shaking." Dr. Stenhouse Williams told me at the end of the operation that the pulse was steadier and better than when we started. The patient did not suffer appreciably from shock, his only discomfort being nausea, which lasted some hours. Several weeks have elapsed since the operation and the patient has lived a life he can bear with comfort, and he complains but little of his hip.

I have chosen these two cases as types in support of the undoubted value of this form of anæsthesia. In one case the patient would not take chloroform; in the other he could not. Cocaine in each instance answered admirably. Cases of this kind are common, and we all have met with many people who forego very necessary surgical procedures

(a) Read at the Liverpool Medical Institution, Thursday, November 17th, 1904.

because they refuse a general anæsthetic. A few words regarding the history and status of spinal cocainisation may not, therefore, be out of place.

It was first suggested and tried by Corning, of Chicago, but Bier and Ieldswitsch were pioneers on the Continent, and Tuffier of Paris, one of the most trustworthy and best of surgeons, used it as a routine anæsthetic. It is perhaps this use of it as a routine anæsthetic which has prevented English surgeons from doing justice to its usefulness. The concensus of opinions abroad is adverse to any attempt at substituting cocaine for ether and chloroform. About eleven deaths have occurred in about three thousand cases, all of which seem to be due to toxic poisoning. If for no other reason this should negative its routine employment. Some surgeons like Tuffier have been remarkably free from catastrophe. When I heard last he had operated upon over three hundred under cocaine, with only one death which might reasonably be ascribed to the drug. Morton, who, like Tuffier, is remarkably good in his *technique*, out of 253 cases had only seen alarming symptoms in one case, and in that case a quantity of cerebro-spinal fluid had been removed for investigation. Stone, out of 441 cases, met with only one death, and I merely mention these statistics in support of the argument that even if cocaine cannot compete with ether or chloroform as a routine anæsthetic, it is sufficiently safe to be used as an occasional substitute in suitable cases. Obviously, for its safe practise an irreproachable *technique* is demanded. The patient's skin should be scrupulously clean. The cocaine solution must be sterile. The glass syringe should be boiled and placed in sterile water. The needle should be introduced between the third and fourth or fourth and fifth lumbar vertebræ. It should be sufficiently long, fine, and not too acutely pointed. The patient should be made to stoop, and the needle should be introduced very slowly and in stages, in order to give the cerebro-spinal fluid time to escape. This is a most important point, otherwise it is easy to traverse the canal. No injection must under any condition take place until the fluid escapes through the needle. The causes of failure in reaching the canal are easily avoidable. They may arise from the needle impinging on the laminae, from failure of the eye to enter the canal, from a clot of blood or tissue, or from traversing the canal. If the needle does not reach the subarachnoid space, it should be withdrawn and re-applied. It is a mistake only partially to withdraw it. Thirty minims of a 2 per cent. solution should be a maximum dose. The cocaine should be introduced very slowly. Some surgeons advocate receiving the abstracted cerebro-spinal fluid in a sterile glass containing one grain of the drug, and re-introducing it into the subarachnoid space. The needle is withdrawn and the puncture sealed. When the injection has been completed, the patient soon feels a sense of warmth through his body, thirst which comes on in about five minutes, and a certain amount of nausea which lasts about ten or twenty minutes. If the patient attempt to walk, some inco-ordination is present, his sense of contact is not affected, but the reflexes are slightly diminished. Intestinal peristalsis and uterine contractions are stimulated. When first administered there is an increase of pulse and sometimes pallor,

perspiration, and vomiting, while sometimes the sphincter action of the vagina, rectum and bladder are abolished.

Analgesia usually begins in the feet and ascends slowly in from three to ten minutes, until it generally ends well above the xiphoid. There is often noted an abnormal loquacity. The analgesia usually lasts for over one hour, sometimes for two or three. The fatal cases have been generally due to direct toxic effects.

In order to convey a general idea of the frequency of annoying symptoms, I will quote Morton's analysis of 253 cases. The ages of the cases operated upon ranged from eight to eighty-six; many of the patients suffered from organic diseases of heart, kidneys and lungs.

Of 253 cases, nausea was present in	65
" " " vomiting	53
" " " headache	37
" " " invol. evacuation	9
" " " post-operative chill	6

One other not unusual symptom I will refer to, and this is a post-operative rise of temperature, ranging from 99° to 103°.

For tropa-cocaine, of which I have no experience, it is claimed that the effects are not nearly as toxic, and are recovered from more quickly, and that thirst, heat, vomiting, and perspiration seldom follow; against this some observers complain that its effects are not sufficiently constant to warrant its substitution for cocaine. Goinard, however, by employing cerebro-spinal fluid as a medium, has given seventy administrations of tropa-cocaine without an unpleasant symptom. It is very necessary, however, to place cotton wool in the ears, and place a screen before the patient to deaden him to his environment. Many symptoms may be due to fear; as Rodman says, discussing pallor, "no one can look at his own blood without misgiving and apprehension."

What are the contra-indications? On this point opinions differ very much. From the point of view of danger Tuffier warns us against giving it to the hysterical and to children. Others with less experience proscribe senile degenerations and renal affections. Morton, with his 250 cases, says there are no contra-indications, although he does not advocate its routine use. I suspect that until the dose is administered, nobody can tell the nervous system to which cocaine is a poison. In doubtful cases I would suggest that a very small subcutaneous dose might solve the problem as to immunity.

Tuffier, although he has performed 200 intra-abdominal operations, six of them being gastro-enterostomies, under cocainisation, thinks the operator may be somewhat handicapped by rigidity of muscle and occasional vomiting, and it seems generally conceded that the drug is best suited to those instances where operations are performed for herniæ, for bladder affections, and for serious operations on the limbs.

My feeling is that spinal cocainisation has come to us to stay, that with careful aseptic precautions the risks are but small; its indications point towards:—

1. Patients not suited for general anæsthetics, such as in those suffering from advanced phthisis and from respiratory affections like bronchitis and asthma.
2. Towards people who have a fixed aversion



to taking an anæsthetic, and on whom an operation is urgently needed.

3. Towards those suffering from great shock due to severe injuries of the lower limbs.

With caution in its employment, and the careful selection of cases, surgery has much to gain from cocaineisation.

## SOME ASPECTS OF METABOLISM—CHIEFLY CLINICAL. (a)

By WILLIAM CALWELL, M.A., M.D.,

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### PART II.

THE mysterious influences of the internal secretion of various organs now come into play. They add a new wonder to life, and are potent for good and evil.

This play of action and interaction form the symptom-complex of nutrition and malnutrition. There may be error in food or error in the preparation, or some defect, initial or acquired, in living matter, or perversion of internal secretion, or some mal-excretion.

The living protoplasm of the cells can apparently most easily assimilate the proteid in the serum, next the carbohydrate, and the fat with the greatest difficulty. The proteid molecule is the most complicated, but also most accommodating, too accommodating at times; not only does it give rise to the simpler molecules of ammonium carbonate and carbamate, but glycogen and a mono-saccharide can be split off, and fat finds a ready origin. This great huge lumbering mass of a molecule has, like the Empire of China, enough to give and to spare. Of all proteid molecules, the nucleo-albumens and cerebrals probably furnish the most complicated of all.

All the chemical processes of cells may be in time reduced to fermentation, the function of the living protoplasm being confined to the determination of the direction of the process at any moment. These ferments are innumerable; there are eight known unorganised ferments in the alimentary canal and a whole array in the body fluids. They bring about composition with an evolution of kinetic energy without themselves being used up in the process. If products of action are removed, the process can go on like the reversible action in chemistry. Those of you who practise the quantitative estimation of sugar by boiling an ammoniacal solution of citric hydrate are often puzzled how to decide when all the copper is exhausted. You boil and the blue colour disappears; but then, as you watch the solution on exposure to air, it regains some of its blueness. You repeat the process, and yet again repeat it. Apparently an indefinitely large quantity of the dextrose can be oxidised by the same solution of copper; this is one of the fallacies of this test; it is called the "reversible action," and in the inorganic world is analogous to the fermentation so richly found in physiological chemistry; the fallacy in practical work is of course avoided by noting the results at the instant that the blue colour first disappears. Another instance is the fact that spongy platinum will effect a rapid reunion between oxygen and hydrogen to form water. Ferment, then, is a factor which adds nothing to the total energy of the reaction, yet materially alters its velocity.

Of the vital action of the protoplasm itself we know little; it is the deepest physical secret of life, next to the material origin of consciousness; it is an ultimate fact.

This, then, is about as compressed a synopsis of the metabolism in our bodies as it is possible to make. From the evolutionary point of view, it is the result of millions of millions of experiments in plant and

animal life, during the last 50,000,000 years. Each living being has been a test tube wherein Nature has been experimenting; we but touch the fringe in the most advanced vital chemistry.

Can we propose now to examine into the question of disease arising—

1. From some perversion of the ferment action, by which albumen is converted into peptone and starch into dextrose;

2. From some perversion of the protoplasmic or synthetic action, by which peptone is re-converted into serum albumen and dextrose into glycogen;

3. From some perversion of the anabolic process of the most highly complicated molecules of living protoplasm throughout the whole body;

4. From some perversion of the katabolic or disintegrative processes?

This would be the theoretical course, but for practical purposes a different and more clinical course will be adopted.

1.—The natural variations in metabolism are infinite—age, sex, temperament, occupation, hereditary influence, and a hundred other minor causes all combine to form permutations and combinations of the force of which we can only make a sort of intuitive guess, but the exact value of which in an individual case under special circumstances baffles us completely when we endeavour to establish a careful estimate. You know of Professor Kraepelin's (of Heidelberg) experiments on certain fundamental properties of mind, as capacity for work, susceptibility to mental fatigue, the power of recovery from much fatigue, the power of concentration, the relation of bodily and mental fatigue, depth of sleep and so on. Many of these experiments and results might be applied by analogy to metabolism if we changed some of the terms. The forces of metabolism vary in individuals as much as the manifestations of nervous energy. They deserve to be more closely studied at the bedside. It is impossible to go into all the variations; two types will illustrate my meaning. We all know the big-boned child with a huge appetite, that is never fat; this type in adult life performs a vast amount of work at a spurt, but is rather deficient in staying power, and takes alcohol badly. The opposite type, the phlegmatic, rather cold child, with poor appetite, eats little, but still is fat; and in adult life often endures prolonged work, and even privation, and shows the strain but little; he can also take for years an unusual amount of alcohol, with at first, at any rate, apparently no further result than being a little too stout.

It is a pity that our old friends, choleric, melancholic, sanguine, and phlegmatic, have completely disappeared from our note taking; they point at the power and changeability of emotions and metabolism, which students now completely ignore, but which they subsequently learn from pure experience with no science to guide them. We should, however, remember the natural variations, and just as there is a slow burning coal and a quick burning coal, even to an explosive petroleum; and just as there is a coal with little ash, and a coal that soon puts itself out by its own accumulation, so we find endless variations in the firing of the human body.

It has occurred to me that we should have some clinical method of examining a patient's metabolism, as we examine his lungs, and heart, and brain. The methods that we find exemplified in experimental investigation in the *Journal of Physiology* are out of place by the bedside; in exceptional instances in hospital the chemical examination of food, urine, and faeces might be undertaken, but the possibility and advantage of any general practice would be more than dubious; as far as we can see, it would not be compensatory for the trouble. I am inclined to think that some such descriptions of the metabolism should be added to notes of our students in hospital.

II.—Next, of the changes that take place in acute starvation one does learn but little. I have seen one case of gastric ulcer where a return to feeding by the

(a) Opening Address delivered before the Ulster Medical Society, Session 1904-05.

mouth was delayed so long on account of previous hæmorrhage that the patient died from actual starvation supervening on excessive hæmorrhage at an earlier date. But although such an occurrence is rare, the gradual starvation that ensues in malignant disease of the cardiac end of the stomach, and the yet more complicated starvation that follows extensive and chronic gastric ulceration, is not uncommon. There was nothing in any of the cases that I have seen that struck me as very exceptional; the natural conservation of energy, the want of mental initiative, the small amount of urine and constipation form a familiar picture. No special examination of the excreta was made. But such cases form opportunities ready to hand for examination into metabolism.

As an instance of changed metabolism due to insufficiency of one kind of food and an excess of another, rickets suggests itself, and then scurvy; their study is valuable not only for the sake of the disease itself, but as types of disease that arise from some small deficiency in food, of little importance for one day, but when repeated daily, week in week out, giving rise to an affection which may be fatal in its severity.

III.—Excessive feeding has been well studied of late in our consumptive sanatoria, and an interesting problem faces us. In Vol. xxviii of the *Journal of Physiology*, details are given by Goodbody, Bardwell, and Clapman of an investigation into the metabolism of three ordinary healthy men, first on ordinary diet, secondly on excessive diet; the results are important, and are summed up as follows:—

The latter in all cases had to be stopped within a few weeks; loss of appetite, hæmorrhoids, dyspnoea on walking, mucous colitis; at first a rapid increase of weight, a subsequent rapid loss, and marked deterioration of health occurred in one or all. This result is interesting with regard to feeding of consumptives. Dr. Howard Sinclair and Dr. Burton Fanning have both written to me to the effect that the limit of diet is probably the same as in health; my own view is that it is more a question of deficiency before than excess after entrance to a sanatorium.

The question of an excess of carbohydrates in food is interesting. No excess of such simple articles of diet as rice appears to disagree in the ordinary individual. Excess of any forms of sugar, di-saccharides, or mono-saccharides soon disagrees, and the symptoms are too well known to need mention. If, however, we inject subcutaneously large quantities of dextrose, 5 to 7 grammes per kilo of body weight, so that it is acted on by the general tissues of the body, not by the liver, it is at once secreted by the kidney, and at the same time causes a marked increase of proteid metabolism. In fact, dextrose, or more probably an acid derivative of dextrose, under such circumstances acts like such toxic agents as phosphorus, poisoning the protoplasm.

These results (which I have taken from V. art. by James Scott, M.D., in *Journal of Physiology*, vol. xxiii) have a bearing on the boils and phthisis of diabetes, and also on the acne spots, the carious teeth of ordinary sweet eating; and this again leads to the variations in susceptibility to the evil effect of sweet-eating. To take our lesson from every-day life, one young lady can scarcely touch sugar without disfiguring her face; her companion in the parterre seems to think nothing of a box of chocolates, and retains the peach-like bloom unspotted. The "protective substance" in the latter must be well developed and able to overcome all the stray staphylococci lodging in her sebaceous glands; or the sieve-like action of her liver must be peculiarly delicate and efficient. People vary enormously in the power of dealing with not only alcohol, but carbohydrates and proteids, and we do not understand the secret.

IV.—Dr. Calwell then referred at some length to cases of diseases resulting from gastro-intestinal toxins and the consequent changes in metabolism. He continued:—

\* V.—Coming to the next class of cases—that by changes in metabolism due to affection of other organs

—I must be content merely to mention the diabetes mellitus that accompanies atrophy or removal of the pancreas; the causal relation is not known; the wasting without diabetes that follows cirrhosis of the pancreas, and has so often misled operators into the opinion of malignancy, is also recognised since Mayo Robson's publication.

Of the kidneys as influencing metabolism we meet not infrequently with the following type of case: A man over 60 complains of some loss of weight, but most of loss of strength and energy; there is a sub-normal temperature, large quantities of urine are passed with low specific gravity, this condition deepens, and after a lapse of a few months he finally dies, being conscious up to his death, perhaps a little delirious; his pupils are small, and there is muscular trembling and restlessness. Most probably an enlarged prostate, discovered during life, but on examination after death there is found hydronephrosis of both kidneys, with but little kidney substance left. This is Roberts' "latent uræmia," and its symptoms coincide very closely with Rose Bradford's results in removing portions of the healthy kidney. He found that when a fraction, say one-fourth, of the total kidney substance was removed, the urine increased in quantity, its specific gravity fell, but there was an increased excretion of urea greater than in health, and as high as when the animal was on a full diet, although now starving. When three-fourths of the total kidney substance was removed the wasting, the subnormal temperature, and great accumulation of urea were observed. There was no coma, convulsion, dyspnoea, vomiting, nor appreciable rise of arterial pressure. The symptoms are not those of Bright's, they point to a peculiar effect of the kidney—perhaps an internal secretion—on proteid metabolism generally. As the pancreas has some peculiar relation to carbohydrate metabolism, so the kidney has some relation with proteid metabolism.

With regard to the effects of the suprarenal bodies on metabolism, it must suffice simply to mention Addison's disease; similarly, with the pituitary body, acromegaly; with the thyroid, exophthalmic goitre, myxœdema, and cretinism; with the testes, the great change that ensues concomitantly with their growth during adolescence, their inhibitory influence on fat formation, their general stimulation of metabolism, and the quite as remarkable a change after their removal; the alteration in the female at puberty, at the menopause, and on artificial removal of the ovaries. The very strong effect of the cerebrum on metabolism is well known; an angry altercation, deep woe, any strong passion for a few hours, make one haggard, and bring down the weight by a few pounds. Literature is full of illustrations. Alienists tell us of the changes that come over the insane in this respect, wasting to excess in acute cases, overgrowth of fat in the dement, the necessity for terrific doses of purgatives all help the picture.

VI. and VII.—Time is left only to mention the effect of such toxins as the fevers on metabolism; and also the effect of such articles of diet or of luxury as alcohol, tea, tobacco, and of such drugs as phosphorus, arsenic, iron, mercury, and salicylate of soda, and last, but most interesting, of phloridzin. Pavy mentions 38 artificial conditions which have been reported as leading to the production of sugar in the blood, which is tantamount to saying glycosuria, as the amount of sugar in the urine is always an index of the sugar in the blood.

VIII.—In treating of the primary or idiopathic forms of diseases of metabolism, one enters upon the most difficult problems of pathology; as our knowledge becomes more exact and extensive, the group becomes smaller. For instance, many forms of glycosuria are secondary; secondary to the food, to functional disturbance of intestine and liver, to disease of the pancreas or of the brain. It is curious that diabetes or glycosuria is not associated with any organic disease of the liver. There still remains however, an apparently primary diabetes mellitus, where sugar appears in the urine, although carbohydrates are disallowed and liver, pancreas and brain show no evidence of disease.

where apparently a dextrose escapes into the blood stream from the huge molecule of living protoplasm, from its own intrinsic weakness of combination. This is the "composite" diabetes of Pavy; whether the excess of urea that accompanies the sugar is also due to the primary disintegration of proteid, or is secondary to the sugar, as in the case of the subcutaneous injection of dextrose, is unknown. The questions of pentosuria, of levulosuria, of glycolytic action of the blood, are yet too *sub judice* to allow any practical deductions to be made.

The opposite type of a primary disease of metabolism is obesity; the tendency is often hereditary; it seems to be a faulty tissue, not a simple failure to effect oxidation. Whether at all, or how far, it is connected with the thyroid gland is uncertain, but cases have been reported of the gland having been found changed. As an instance of the want of proper testing of methods of treatment, Von Noorden relates the case of a stout lady, who submitted to massage of one arm; massage was a vaunted remedy for obesity, and warranted to remove an overplus of adipose tissue; however, at the end of a suitable time, the circumferences were again measured: the arm which had not undergone treatment remained as before; the other had increased one and a half centimetre.

I now come to some other, rather rarer forms of apparently primary disorders of metabolism. One has received the name azoturia; it is a rare condition, we commonly enough see milder forms of it, or perhaps more truly, we see mild acute attacks of it; there is an excess of urea and urates; this causes a certain amount of polyuria, a feeling of languor, weariness in loins and thighs, a disordered stomach, dirty tongue, and disturbed appetite, with loss of weight. I have seen several mild instances of it, and the patients were all more or less under the influence of some pretty powerful emotion. As a pure proteid diet does not stop a primary diabetes, so a pure carbohydrate does not stop this azoturia. Some cases are reported as running into diabetes. An analogous condition called baruria, where there is a general pathological increase of the solid constituents of the urine, is also reported; the symptoms are much the same as in azoturia. Whether under this head we should include diabetes insipidus or not is debatable. However, we must include "phosphaturia" or "phosphatic diabetes," of which most of us have come across at any rate mild types of, although a rare affection. By this term is not meant phosphates deposited in alkaline urine, or the triple phosphates due to decomposition, but a pathological constant increase of earthy phosphates. We find phosphates somewhat excessive in gout, where it may alternate with uric acid, and also in the opposite kind of disease, namely, phthisis; phosphates are said to be increased by administration of ovarian substance; and although excess of these salts is not found in mollities osseum, yet removal of the ovaries is said to arrest this disease. Like uric acid, phosphates are derived chiefly from the food, but some come from tissue disintegration; the urine removes the alkaline phosphates, but the mucous membrane of the intestine removes the phosphates of calcium; and, lastly, phosphates are diminished in Bright's disease and are in excess where uric acid is in excess—namely, where there is a breaking up of nuclein into its proteid and purin radicle. It is said there may be a renal inadequacy for phosphates, as there is for urea, and as we shall see for chlorides. Von Noorden lays considerable stress upon these phosphates, and advises in Bright's disease the administration of carbonate of calcium several times daily in milk, as he says by this means half of the phosphoric acid remains in the intestine, or after circulating in the body is poured into the intestinal secretion and appears in the fæces, and so the kidneys are spared. We thus see that there is more than empirical reason for adding lime water to milk.

The symptoms of phosphaturia are much the same as in azoturia—namely, emaciation, nervous irritability, dyspepsia with pain in back and loins; and the ill-health may deepen into phthisis or diabetes.

Under the same heading and with much the same symptoms comes oxaluria, which need not delay us.

While on this subject of what has been called the "demineralisation" of the tissues, one must not omit the theory lately advanced by some French clinicians, that if sodium chloride is not eliminated by the kidneys at a rate proportional to its absorption, the salt accumulates in the tissues, causing a hydration which leads to œdema. The excretory power of the kidneys for common salt in some cases of Bright's disease is less than in health; the opinion was advanced that chloride retention was a sign of renal inadequacy. The figures given are as follows. A man eats about 15 grammes of salt every day; healthy kidneys can excrete more than 30 grammes, but diseased kidneys perhaps not more than 2 or 3 grammes; urea, phosphates, and other urinary constituents may remain normal. In some cases of tubular nephritis with œdema there is a renal inadequacy for sodium chloride; the opposite condition is said to exist in some cases of chronic interstitial nephritis, in which a state of hyperchloriduria is present, by which the tissues are dechlorinated. We thus seem to have a disassimilation for nitrogen, for phosphates, and now for chlorides. On the other hand, in one case, more chloride was excreted than had been absorbed; the tissue, instead of fixing some of the salt, had lost part of what it had already held; the symptoms were polyuria, thirst, absence of œdema, and hyperchloruria. On *post-mortem* examination both kidneys were very small. (*Practitioner*, November, 1904.)

The result of these statements is that in future we must pay more attention to the quantitative analysis of urine for such salt, and endeavour to find out in how far they are primary diseases or merely signs of a disease. The treatment of all these conditions of which pathology is obscure, but in which the nervous element in my experience is the most important, is much the same—rest, quietness, removal from all sources of emotion, cold salt bathing or sponging, and acids, cool rooms, and light clothing and purified food. Of drugs, I think opium should be tried in cases that do not yield to hygienic measures.

## A FATAL CASE OF ŒDEMA ASSOCIATED WITH ALBUMINURIA IN AN INFANT AGED EIGHT MONTHS. (a)

By GEORGE CARPENTER, M.D.,

Senior Assistant Physician to the North Eastern Hospital for Children; late Physician to the Evelina Hospital for Sick Children.

MAUD S., æt. 8 months, was brought to the North Eastern Hospital for Children on December 7th, 1903, with a history of having wasted since measles, ten weeks previous. Her abdomen was prominent, and her liver extended three fingers' breadth below the costal margin in the nipple line. She was neither rickety nor anæmic, and there were no physical signs. Her mother had borne six children; she had one born dead and one still-birth, and had produced three children, living, since then. On Dec. 4th the child was considered to be progressing well, but a week later her face began to swell, and then her hands and feet. The illness commenced with sickness every time she took the breast. She did not pass much water, and it was said to be a "kind of brown colour." On January 4th her face was waxy-looking; both eyes were œdematous, the right eye especially. The feet and legs were very dropsical, deeply pitting on pressure, also the trunk; and the feet were cold and blue-looking. The buttocks and groins were raw-looking and weeping. On the right cheek there was a tiny cutaneous gamma

(a) Read before the Society for the Study of Disease in Children, February 19th, 1904.

with a reddened surface, the size of buck-shot. The mucous membranes were rather pale. There was also a number of superficial lesions on the cheeks, the size of hemp-seed, with a certain amount of surface exudation, which the mother said came out like yellow blisters. She was admitted into the hospital. On January 7th the œdema of the trunk had increased slightly, and that of the eyes had decreased. The spots on the face were more numerous. The smallest quantity of urine which had been passed was 4 ounces in the twenty-four hours, the largest 5 ounces. The highest pulse-rate per minute was 116, the lowest 92; the highest respiration-rate 36, the lowest 24. The temperature was about 97° F., the highest 97.8° F. There was a decided cloud of albumin in the urine, and a sediment on boiling. On January 8th the œdema was less on the dorsa of the hands, and on the right side of the trunk. œdema was well marked on the inner side of each thigh, the fronts of the legs, and the backs of the feet. There was slight œdema round the umbilicus. The most marked swelling was on the buttocks, where several drops of serum could be seen exuding from the surface, which was red and shiny. There was no lumbar œdema. On January 9th the urine was thick and cloudy, and contained 1 gramme of dried albumin per 1,000 c.c. The urea amounted to .4375 grain per ounce. The œdema was less in the morning than at night. On January 10th there was a slight trace of albumin, and the urea was .4375 grain per ounce. On January 11th there was a slight trace of albumin. The swelling was slightly less than before. On January 12th there was a slight trace of albumin; there were no tube casts. The largest quantity of urine that had been passed since the previous record was 5½ ounces, the smallest quantity 3 ounces. The child was in a very precarious condition; no radial pulse could be felt, and the breathing was shallow and irregular, and she died on January 13th. The *post-mortem* examination was made on the same day. The brain, which weighed 23 ounces, was normal. The heart was healthy. The right lung weighed 2½ ounces; it was in part œdematous. The left weighed 2½ ounces, and was in a similar condition. The liver was pale; it weighed 11½ ounces. The right kidney weighed 1 ounce, the left 1½; neither appeared abnormal. The spleen weighed ¾ ounce. The stomach and intestines were normal. Microscopically, nothing abnormal was detected in the kidneys. The liver was fatty; the heart was normal. Some small patches of broncho-pneumonia were found in the lungs.

*Remarks.*—In the absence of definite pathological changes in the organs one is forced to fall back upon the explanation of toxæmia to account for the symptoms during life, though how and where the toxin was manufactured which produced the fatal result the autopsy does not show.

## Transactions of Societies.

CLINICAL SOCIETY OF LONDON.  
MEETING HELD NOVEMBER 25TH, 1904.

DR. FREDERICK TAYLOR in the Chair.

### CRISES IN COURSE OF POSTERIOR BASIC MENINGITIS.

DR. C. R. BOX read a paper on certain paroxysmal exacerbations of symptoms which occur during the

progress of posterior basic lepto-meningitis in patients whose cranial fontanelles have closed. These exacerbations he proposed to call "the crises of posterior basic meningitis." In the most complete form this complex of symptoms is as follows: The temperature suddenly rises from subnormal or near normal to a considerable height—it may be as much as 7° F. The patient experiences a feeling of chilliness or even has a rigor. Headache, frontal or vertical, sets in and often is accompanied by vomiting. The neck becomes stiff or retracted and the mental condition is dull. At the same time the pulse-rate does not fall, but, on the contrary, is usually increased. The temperature remains high for a short time and then may fall as abruptly as it rose, the urgent symptoms at the same time subsiding. The whole crisis may be over in a few hours, or it may be twelve hours or even more before the normal condition is regained. In one case the lateral column symptoms, exaggerated knee-jerk clonus, &c., were decidedly exaggerated during the paroxysms. Five cases were reported, three of which showed the crises in a typical form and two in which the crises, although present, were not so prominent. Lantern slides of the temperature charts were demonstrated. Dr. Box remarked that this form of paroxysmal pyrexia was not included in the list formulated by Murchison, but apparently was recognised by Bristowe. Attention was drawn to the fact that the co-existence of secondary deafness or of secondary otitis media in posterior basic meningitis might give rise to considerable difficulty in distinguishing cases in which the crises occurred from cases of ear disease with secondary intracranial complications. Temporary increase in the intra-ventricular pressure was suggested as the cause of the exacerbations, and the advisability of lumbar puncture or of some other operation for the relief of the pressure was suggested.

DR. F. E. BATTEN was not familiar with the class of case described, as they were in patients over the age of nine. In young children, however, he had frequently observed this sequence of symptoms. He asked what evidence there was that the cases were true posterior basic meningitis, *i.e.*, due to Weichselbaum's diplococcus. He hardly thought the term "crisis" an appropriate one, as that indicated either a turning-point or a critical period. The rise and fall in temperature might occur as described, with no other symptom except a little cyanosis of the extremities. The fall was just as characteristic as the rise, and he had seen greater falls, *e.g.*, to the extent of 10° F. in twelve hours. As, however, the same series of symptoms might occur in such conditions as hydrocephalus, middle ear disease, suppurative pericarditis, he could not agree that they were characteristic in any way of posterior basic meningitis.

DR. PASTEUR thought that the term "crisis" was a bad one. A point that struck him was that the drowsiness was present in between the attacks, and not at them, this being much against their being due to increased intra-ventricular pressure.

DR. TAYLOR similarly wanted to see justification for the use of the term crisis, though it had a wider meaning than that given by Dr. Batten, as evidenced by its use in locomotor ataxy. He had never seen the phenomena described in the course of posterior basic meningitis, but had seen it on one occasion apart from that condition.

DR. BOX said that he applied the term to the whole syndrome and not to the temperature alone, and thought that he was justified by its use in reference to floating kidney. Bacteriological tests were applied in only two cases; in one a streptococcus was obtained and in another an organism of indeterminate nature. Clinically, however, the cases were clearly posterior basic meningitis.

A CASE OF UNILATERAL TUBERCULOUS MENINGITIS IN WHICH A BULLOUS ERUPTION FOLLOWED LUMBAR PUNCTURE.

DRS. H. D. ROLLESTON and TEBBS described the case

of a boy, *æt.* 5, who was perfectly well until, after a day's malaise, he was seized with general convulsions, more marked on the right side, with conjugate deviation of the head and eyes to the right. Lumbar puncture was performed between the spines of the third and fourth lumbar vertebræ, and subsequently a cannula was introduced in this position and cerebro-spinal fluid, which at first was blood-stained, allowed to run away. On the following day, on the afternoon of which death occurred, two bullæ appeared on the outer aspect of the right little toe. The whole illness occupied five days. At the necropsy there was tuberculous meningitis, limited to the left Sylvian fissure, which was thought to be due to an embolus derived from a caseous gland invading the apex of the left lung. There was an elongated blood clot three inches long under the arachnoid and in contact with the posterior nerve roots of the cauda equina on the right side. This clot, which was probably due to lumbar puncture, was regarded as having irritated the posterior nerve roots and ganglia and produced a bullous eruption resembling herpes.

Dr. Box said that the case was of interest in that it showed that lumbar puncture, though of great service, was not always harmless. He had twice seen extensive intra-meningeal hæmorrhages follow the operation.

Dr. BATTEN asked whether the first sacral ganglion had been examined. He pointed out that the posterior root ganglion was some distance away from the site of puncture. The evidence that a subdural hæmorrhage, or any other injury of the posterior nerve roots apart from the ganglion, could produce a herpetic eruption was very slight.

Dr. A. E. RUSSELL said that the case was of considerable interest from a physiological side. Bayliss had shown that stimulation of the peripheral end of a cut posterior nerve root caused great vaso-motor changes in the limb supplied.

Dr. H. D. ROLLESTON said that the sacral ganglion had not been examined.

#### POST-OPERATIVE ACUTE LOCAL TUBERCULOSIS.

Mr. EDRED M. CORNER and Dr. LEONARD S. DUDGEON described a case in which, after an operation for tuberculous glands of neck, a local tuberculous infection of all the surrounding tissues occurred. The chief sign of this infection was local swelling after the wound had healed. The case therefore sheds light on the nature of "swellings" seen after operations for tuberculous lesions. Several cases were narrated to illustrate this in connection with glands of neck, tuberculous disease of the knee-joint and kidney. In these instances, and in many more, not specifically quoted, the healing of the wound had been by first intention. Local infection does not seem to occur, or perhaps it occurs only in lesser intensity and degree if the wound is left open or drained. The question of the advisability of the employment of drainage after such operations is raised; and where there has been obvious chance of infection occurring, as if glands burst whilst being excised, and the situation allows of it, the sounder surgery is to close the wound incompletely and employ drainage.

Mr. F. C. WALLIS urged that better results than those described were obtained by draining the wound for twenty-four hours so as to allow of the escape of the inevitable collection of serum that took place.

Mr. W. G. SPENCER had never seen such a case after antiseptic operations. He thought that its occurrence was due to incomplete removal of diseased tissue, and urged more extensive operations in tuberculous cases. He had been impressed by the latency of tubercle bacilli. This was well shown in the lighting up of old foci after injection of Koch's tuberculin. The activity of the micro-organisms was far larger than appeared clinically.

Mr. R. P. ROWLANDS asked whether in the kidney case described infection through the ligature could be excluded. Another fallacy was disease of the ureter. He had seen recurrence after this had been incompletely removed.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND.

##### SECTION OF OBSTETRICS.

MEETING HELD NOVEMBER 18TH, 1904.

DR. A. J. SMITH, President, in the Chair.

DR. A. J. HORNE showed a case of Elephantiasis of Leg and Vulva.

Dr. W. J. SMYLY showed a specimen of Cancer of Both Ovaries. Patient, *æt.* 66, ceased to menstruate at 54. In April last there was a slight red discharge which ceased, but came on again in three months. Scrapings from curetting were benign. A small tumour could be felt on each side of uterus. In November a large ovarian cystoma had formed. Uterus and both ovaries were removed by Doyen's method. The second case was Tuberculous Pyosalpinx, and in it the uterus and appendages were removed by the same method.

Dr. E. H. TWEEDY asked if there were adhesions behind the uterus in these cases, as Doyen only employed his operation for myoma of the uterus. Also, would he remove pyosalpinx by that method in every case?

Dr. R. D. PUREFOY thought the question of diagnosis was interesting. A malignant tumour sometimes simulated pedunculated fibroid very closely. He did not see why the uterus should be removed in every case of removing the tubes. He had found great advantage in operating on these cases from trying the ovarian artery in the infundibular pelvic ligament.

Dr. KIDD thought it too sweeping to say that the uterus should be removed in every case of removal of the tubes. He related a case of pyosalpinx of both tubes, which drained into the uterus from time to time. The patient was too weak to be operated on. She afterwards got perfectly well, and bore a living child.

Dr. A. J. SMITH said he used to be content with removing the tubes in tuberculous disease, but then found that patients often came back complaining of pains, which he thought were due to adhesions. In one case he operated again and found a large tuberculous mass, and now he always removed the entire uterus. In ordinary cases of pyosalpinx he had not yet adopted it.

Dr. PUREFOY wished to know how one would recognise these cases of tuberculous tubes, if he advocated the removal of the entire uterus in these cases only.

Dr. SMYLY, in replying, said that in these cases of pyosalpinx, tuberculous or gonorrhæal, the tubes were twisted and surrounded by dense adhesions, rendering it very difficult to get them out. The chances were very much against cases being like Dr. Kidd's, in which there was drainage. His own experience was like Dr. Smith's—that is, having patients coming back after removal of the tubes only, and he thought now that the uterus should be removed in most cases. In the case he had shown there were a lot of adhesions behind the uterus.

#### DR. A. J. HORNE opened a discussion on THE INFLUENCE OF FIBRO-MYOMATA ON PREGNANCY AND PARTURITION.

Dr. W. J. SMYLY said that the general impression was, that women with fibroids were less likely to conceive than others, but these women were generally sterile long before. The cause of sterility appeared to be the condition of the mucous membrane. Another point was that these women went on bearing children to a later period in life than others, and it was attributed to ovulation and menstruation going on to a later period. His own experience did not either support or contradict these opinions. He thought that these tumours did not often cause obstruction during labour, even when growing low down in the pelvis, as they were usually drawn up out of the way. He related a case in which there was a subperitoneal myoma, pushing the peritoneum up, and the vaginal mucous membrane down. He had to do Cæsarean section and remove the uterus and tumour. In another case there was an interstitial myoma in the lower uterine segment. The patient went into labour for a few hours, and then labour pains apparently ceased; came on again in a few hours, and membranes ruptured.

She was in labour on and off for a week. The os then allowed two fingers in, and a foot was pulled down, and after a long time the foetus came away. He thought the chief danger of myomata was during the puerperium. In one case a hospital patient died from *post-partum* hæmorrhage, and, *post-mortem*, a submucous myoma was found, the size of an orange. He had also found that portions of the membranes were retained sometimes in these cases, which decomposed and caused sepsis. Retained placenta was also common. He did not agree with Bland-Sutton that all myomata should be removed, though the risk of operation was not great.

Dr. PUREFOY thought the influence of fibroids in causing sterility was over-rated. An interesting aspect of the question was the greatly increased difficulty in diagnosing pregnancy in the first three months. If a myoma invaded the cervical region it was most difficult, as he thought the cervix did not undergo the characteristic amount of softening of pregnancy. He related a case in which a fibroid occupied the pelvis, and he did Cæsarean section. A fibroid in the uterine wall also enfeebled the uterine contractions, and they often caused marked interference with the course of labour. He related another case of a primipara, æt. 30, with a fibroid in the lower uterine segment. She went five weeks beyond full term. The presenting part could not be reached, and there was a complete absence of labour. The uterus was removed along with the child, and the patient made a good recovery. Displacement should be done in these cases if possible, and he thought myomectomy was only advisable in the early months of pregnancy. He tabulated these cases in the Rotunda, and noticed an absence of *post-partum* hæmorrhage. Most of the patients were young women, æt. between 30 and 40. He suggested that the occurrence of pregnancy rather hastened the development, and increased the size of these tumours.

Dr. E. H. TWEEDY related a case in which he had removed the uterus at the fifth month, as the patient could not have gone on to full term. As to fibroids causing sterility, he said it was not the fibroids, but the endometritis that caused it in a certain number of cases. If there was a subperitoneal myoma it would not cause endometritis, and there would be no sterility. Another point was that they might directly cause twisting, or pressing, or stretching of the tubes, which might cause sterility.

Dr. KIDD agreed as to the difficulty of diagnosing pregnancy in the early months, when associated with myomata. As to sterility, he thought the question was one of comparative and not absolute sterility. He related a case of a primipara, æt. 44, with two large tumours at the fundus. They caused transverse presentation; version was done. The placenta had to be removed manually. Patient made a good recovery. He had examined the patient since, and found that the tumours had entirely disappeared. When pregnancy was complicated by cancer, the cancer usually increased rapidly, owing to the hyperæmia. He thought the same increase usually occurred in the case of other tumours under similar circumstances. He related another case in which a tumour sprang from the posterior wall of the supravaginal portion of cervix. Panhysterectomy was performed, and the patient made a good recovery. In another case in which a tumour was present which could not be lifted out of the pelvis, Cæsarean section was performed. Two years later the patient again came into hospital, after she had been in labour for 73 hours. On this occasion it was possible to deliver her with forceps. In another case labour was induced, but soon ceased. A tumour, the size of a hen's egg, was then enucleated from the cervix; after ten days labour came on again, and the patient delivered herself.

Dr. JELLETT said that another aspect of the question was the effect of myomata on the life of the ovum during the last months of pregnancy. Quite recently, he had had a case in which death of the foetus *in utero* apparently resulted from a myoma of the fundus. He saw a patient in February last who was expecting

to be delivered about May 1st. She went all through May, and then a myoma, the size of a cocoanut, was found on the anterior wall of the fundus. A dead and macerated child was born on June 3rd, and the placenta was little more than the normal size. He was interested to know if such a case could be attributed to the myoma, or whether it was a mere accident of pregnancy. If the former, there were two views of the case. First, was the patient's history correct, and should she have been delivered on May 1st, and did the myoma affect the innervation of the uterus, and prevent labour coming on at the proper time? Secondly, did the myoma interfere with the development of the placenta? This was probably the correct view. Four months after the labour he found another myoma on the posterior of the fundus, so that there was very little healthy area at the fundus for the placenta. It then became a question of how close the myomata lay to the mucous membrane, as if they lay very close there might not be sufficient room for the uterine sinuses to develop and hence an insufficient circulation. After a certain period, then the foetus would die from interference with the placenta. One cause of sterility in cases of uterine myoma was probably to be found in cystic degeneration of the ovaries.

Dr. A. J. SMITH related two cases. The first had a large fibroid tumour, the size of an eighth months pregnant uterus. There were no urgent symptoms, but there was no room for a pregnant uterus along with the tumour. He removed the tumour and the following year the patient was delivered of a full term child, and had had four since. The second case was one of six months' pregnancy, complicated by a large fibroid tumour. There was great distress and dyspnoea, and the tumour was removed along with the pregnant uterus. This was another example of the danger of a large fibroid tumour in pregnancy.

Dr. A. J. HORNE, in replying, said he never knew of a primipara, æt. more than 47. He said there were two questions he had avoided in his paper, first, the diagnosis of fibroids with pregnancy, and, second, their after-effects on the puerperal state. In the case he had with Dr. McArdle, the patient was six months pregnant. There was a tumour in the right hypochondrium, which overshadowed the uterus, but there was a distinct line of demarcation. It only gave rise to slight pressure symptoms, and the pregnancy went on to full time. There was a breech presentation. As to *post-partum* hæmorrhage, he had always referred to the danger of it in these cases, but had seen many without it. He did not see how sterility was caused by pressure on the oviducts, as in these cases there was excessive menstruation.

THE BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION.  
ANNUAL GENERAL MEETING HELD NOVEMBER 11TH.

MR. BARK, and subsequently MR. CHICHELE NOURSE presiding.

A VOTE of thanks to the retiring president, Mr. Bark was proposed in terms of cordial appreciation by Dr. DENNIS VINRACE, who referred particularly to the long distance travelled by Mr. Bark in order to carry out his presidential duties. This was seconded by Dr. WYATT WINGRAVE, and carried unanimously.

Dr. KELSON described a case in which the patient came complaining of hoarseness of several years' duration, but recently increasing. There was no history of syphilis, tubercle, or malignant disease. On examination, a pinkish growth was to be seen occupying the anterior commissure and anterior part of the left cord. A portion of this has been removed, and proved to be a papilloma. The movement of both cords was good.

Dr. WYATT WINGRAVE showed a case of "Salivary Calculus Simulating Angina Ludovici in a Male, æt. 30." A male patient came to hospital with considerable swelling immediately beneath the jaw between the tongue and the hyoid bone. It was very painful.



and he could not open his mouth more than half an inch and there was considerable difficulty, not only in breathing but in swallowing and masticating. The voice was characteristic of that of a patient suffering from acutely inflamed tonsils. The swelling all round led him to the belief that it was a case of angina Ludovici, perhaps associated with inflammation and suppuration of the lingual tonsils. As far as he could see the latter were distinctly enlarged and they completely hid the epiglottis. But on running the fingers along the floor of the mouth and around the tongue he came upon a hard resisting surface at the side of the frænum, and that he pressed upon, perhaps more than usual, and discovered a very hard point projecting. It was a salivary calculus, and when the calculus was removed there was a discharge of pus from the surface. The swelling went down and the patient was all right in a few days. The case was interesting from the point of view of differential diagnosis. The stone was in Wharton's duct.

Mr. W. STUART-LOW explained that Dr. Abercrombie had hoped to be present, but found it impossible, and he had therefore asked him to read the following description of a somewhat similar case:—In connection with Dr. Wingrave's case, the following notes of a similar one occurring in my (Dr. P. H. Abercrombie's) practice may prove interesting. I was consulted on April 25th last by a man, æt. 54, a commercial traveller, who complained of a painful swelling under the chin and left side of the tongue of between two and three weeks' duration. The swelling, which was very evident on inspection, was situated under the chin and the left side of the lower jaw, and was hard to the touch and very tender. It had pushed up the tongue and interfered with speech, and swallowing was difficult and painful. There was considerable constitutional disturbance, and the patient's facial aspect was one of great suffering and anxiety. Carious teeth were present in the left lower jaw, and there was enlargement of the left submaxillary lymphatic glands. I incised the sublingual swelling in the mouth and some fetid pus escaped, but I failed to detect any stone with the probe. A few days later, however, the two specimens of salivary calculus which I show to-day were found loose in the mouth, and removed by the patient. After this he recovered rapidly, and was soon quite well.

Dr. WYATT WINGRAVE on a case of "Epithelioma of the Laryngo-Pharynx, wearing Jacques' Œsophageal Tube." The patient was a man, æt. about 60, who came eight or nine months ago to the hospital complaining of difficulty in swallowing. It was evidently a case of epithelioma involving the lower part of the laryngo-pharynx. The infiltration was extensive, so that it was inoperable, and in order to feed him a Jacques' tube was passed through the Œsophagus into the stomach, and then it was caught by passing a loop through the nose, and brought up through the nostril and carried over to the ear, where it was fixed. The man was then taught to introduce the food by that means. It was interesting from the point of view of how long such a state of matters could exist. The man had never had the tube out for seven months, and beyond a certain amount of discomfort from the factor he was none the worse for it. It certainly was not very nice, from an æsthetic point of view, to have a tube over the ear, but the patient could swallow with it, and feed himself remarkably well. He was now able to correct the unpleasant factor which existed at first by having a mouthful of sanitas and water and swallowing it until it reached the constriction, and then eructating. The pain was so great that he ordered him a grain of powdered opium to mix with his tobacco, and that gave him more comfort than anything else. The last he heard of the patient was that he was doing well, and that he had not lost in weight.

Dr. KELSON agreed with Dr. Wingrave with regard to the utility of those tubes in such cases, and described a particular case.

Mr. BARK thanked Dr. Wingrave for bringing the case forward. One knew the difficulty there was in conducting comfortably and peaceably those inoperable

cases to their final destination. His own experience in the use of tubes for feeding and the dysphagia produced by laryngo-pharyngeal carcinoma had been in the use of Symonds' tubes. He had found those tubes very unsatisfactory in most cases. The patient very soon rejected the tube. He was very pleased to hear of the Jacques' tubes and that they could be retained in order to feed the patient, who would otherwise inevitably die of starvation.

Dr. ANDREW WYLIE: Case of "Epithelioma of the Auricle."

Mr. STUART-LOW apologised for the absence of Dr. Wylie, and said that gentleman desired him to ask the opinion of Fellows as to whether he should operate in that case, which had been proved microscopically to be epithelioma. Could the whole of it be got away by operation?

Dr. HASLAM (Croydon) asked whether there was any enlargement of the lymphatic glands in the case.

Mr. STUART-LOW replied that the deep lymphatics were enlarged, and also those well behind the jaw. Of course, the operation would have to be a very radical one, and that was why Dr. Wylie was doubtful as to the expediency of operation.

Dr. WYATT WINGRAVE thought an entire removal of the disease was fairly probable, although it was difficult to say to what extent the meatus was implicated, and how far the growth was connected with bony wall.

Dr. DUNDAS GRANT: "Exostosis of the Auditory Meatus."

Dr. ATKINSON, in Dr. Grant's absence, explained what had been done in the case. The exostosis presented close to the external auditory meatus, and he first of all used a dental burr, and into the aperture made by it introduced an instrument like a large wool-holder, working in a corkscrew fashion. He simply twisted that in, and the exostosis came out quite easily. There seemed to be none of the growth left behind.

Dr. HASLAM (Croydon) asked why Dr. Dundas Grant operated in the case, because he believed it was an understood thing that the best plan was to leave an exostosis alone unless it was complicated by disease. Was it a pure exostosis, the result of which was some obstruction and deafness?

Mr. BARK said that evidently an exostosis of that size in the external auditory meatus would cause a large amount of deafness, and if it were easily removable, as in the present case, that operation would be perfectly justifiable. The exostosis appeared to have had a pedicle, and therefore it was an excellent case for removal.

Dr. WYATT WINGRAVE showed a case of "Primary Chancere of the Nose."

Dr. VINRACE said he did not feel satisfied as to it being a primary ulcer of the nose. He asked whether the inoculation was not due to conception. One often saw such cases where the subjects were healthy until pregnancy, and then they showed manifestations in different parts of the body. Possibly the nose was an uncommon site, but he thought it would be found to be secondary to needle inoculation.

Dr. WINGRAVE said that, first of all, the patient had a slight discharge from her nose. There was swelling and stiffness referred to the root of the nose. That disappeared, and in a short time a small pimple showed itself at the edge of the nostril, which gradually spread but did not discharge. The discharge came from the interior of the nose. The swelling got much harder, but about three weeks ago it began to soften. She had complained for the last week or so of an amount of soreness in the throat. But in addition there was a well-defined rash, which had been partly on her trunk, but chiefly on the extensor aspects of the forearms, and to some extent on her legs.

Dr. VINRACE said he feared he had been misunderstood. He did not doubt the nature of the complaint—it was syphilitic, but he doubted the actual causation of the lesion. He regarded it as a case of inoculation through the fœtus and not an inoculation by direct

contact, forming a primary sore. Was the patient pregnant or not?

Dr. WINGRAVE, in further reply, said he could not give any history with regard to the inoculation. She had been married fourteen months, and the woman did not think she was pregnant.

Dr. WYATT WINGRAVE showed a case of "Cystic Disease of the Antrum."

The PRESIDENT showed a case of "Disease of Sinuses." He said it was a case of disease of sinuses in which a permanent opening had been made into the inferior meatus of the nose.

Mr. BARK said he was never in favour of treating antral suppuration by an opening such as that described. He preferred, if he were going to make an extensive opening into the outer wall of the nose or the inner wall of the antrum, to do the complete operation, to remove the external wall and the superior maxilla. If for any reason, such as the objection of the patient, he could only do a tentative operation, he preferred to make an opening into the canine fossa and insert an indiarubber tube, by means of which the patient could cleanse out the antrum through the nose.

The PRESIDENT replied that he had a particular reason for not doing the radical operation in the present case. One point was that it was not clear to his mind whether it was a case of simple myoma or actual sinusitis of the antrum. And in cases where one desired to open the sinus without doing the radical operation he certainly did not care to make an opening into the mouth, because the mouth, being a septic cavity, it very often happened that re-inoculation took place and the suppurative abscess continued indefinitely. That patient had had no trouble whatever in the manipulation of her tube; she passed it quite easily, and it kept the sinus washed out. Otherwise he endorsed Mr. Bark's remarks about the desirability of doing the complete operation.

The PRESIDENT showed a case of "Maxillary Sinusitis." It was shown on account of the ease with which the sinus could be catheterised through the infundibulum.

Dr. VINRACE asked how long it was suggested catheterisation should take place. Was it to be done to the end of the patient's life, or gradually relaxed and finally left off?

Mr. BARK said he supposed that the frontal sinus was cured, and that the case was simply brought to see how easily the sinus could be catheterised.

Dr. HASLAM (Croydon) said he presumed that infundibulum was not as it would be in an old case in which there were secondary changes. It would, no doubt, be necessary to do the radical operation if it were an old case in which there were secondary changes. He would be glad to hear how long the catheterisation had been continued.

The PRESIDENT, in reply, said that when he first saw the case the frontal sinus on that side was patent through the infundibulum, but empty. There was no sinusitis. He mentioned the fact of the antral sinusitis, for which he had done the operation, as being part of the case, but that was not the reason he showed it.

The PRESIDENT showed "An Aural Case for Diagnosis."

Dr. CLAYTON FOX suggested that possibly the case might be one of keloidal formation secondary, probably, to some small cicatrix, which was first started by the rubbing of the hairpin which the patient had been using. It also had somewhat the aspect of a sebaceous cyst, but against that was the fact that it was lobulated.

Mr. McDUGALL (Liverpool) said he thought the case was one of chronic furuncular inflammation, and that dealing with it radically, by thorough scraping, would probably cure it. He did not think it presented the appearance of keloid at all.

The PRESIDENT said his own idea on the matter was that it was possibly a form of external otitis due to some bacterial infection, but there had been no chance yet of making any microscopical investigations.

#### MICROSCOPICAL SPECIMENS.

Dr. WINGRAVE said he wished to remark only on one of the specimens he showed, that of tuberculous cervical lymphatic glands. Of late he had examined a large number of such cases, although he was doubtful as to why they should be called tuberculous. It was true that one found in them giant-cells and practically all the evidence of tuberculosis except the bacillus. The remark would apply equally well to lupus, in which no tubercle bacilli were found. The granulation cells were found in granulomata associated with syphilis, more particularly the tertiary stage, but there were no micro-organisms to be found which were obviously connected with the disease. That specimen exhibited and a number of others he had stained most carefully for evidence of tubercle bacilli, but without success. And on examining those glands, particularly those which were removed before there was any sign of suppuration, there was no sign of any definite character of tubercle; there were simply hard dense masses of epithelioid cells, and a certain amount of interstitial fibrotic change. Many of those suppurating glands were found terminating in pus, and pouring out large quantities of streptothrix and other organisms, so that there were a large number of so-called tuberculous glands which were not due to tubercle at all, but which presented all the histological features minus the specific organism. So it was likely there might be infection from streptothrix from the tonsils and adenoids from the ear and other channels, which gave rise to the characters of so-called tuberculous glands, but without presenting the respective micro-organisms.

Dr. JOBSON HORNE said that Dr. Wingrave had touched upon a very important subject. Although the difficulty of staining sections to demonstrate the tubercle bacillus was a common experience, he did not think it should lead one to jump to the other extreme and say that the glands so examined were not tuberculous. A similar condition of things was met with in adenoid tissue and post-nasal growths, and in tonsils and, indeed, in lymphoid tissue generally, i.e., there were sections such as that excellent one under the microscope demonstrating giant-cells and all the histological structures of tubercle, but not the all-important bacillus. But it was questionable whether one should say that the bacilli were absent from that section. He thought one should not go further than to state that they were not stained. And the reason they were not stained, although the section had been treated with the most perfect technique, was, for some occult cause, to be found in the action of the lymphoid tissue itself upon the organism. By way of demonstrating whether such a gland was or was not tuberculous, the following little animal experiment would be of interest. A patient had tuberculosis of the temporal bone, and he injected a portion of the tissue into a guinea-pig. In due course a gland adjacent to the site of inoculation enlarged and also more distant glands. He inoculated two pigs with it. One he killed before it had run its full term, and examined the glands. In the largest gland, that next to the site of the inoculation, he was able to demonstrate sections very similar to that shown by Dr. Wingrave, that is to say, having all the histological structure of tubercle but none of the bacilli. The same was true of the other smaller glands. But upon inoculating a third guinea-pig from the first and largest gland which demonstrated no tubercle bacilli under the microscope, he was able to kill that guinea-pig with tubercle and to demonstrate in the animal tubercle bacilli. Therefore he thought it would be more correct to say that one failed to demonstrate tubercle bacilli in a gland rather than to say that they were not present.

Dr. WYATT WINGRAVE demonstrated a syringe for intra-laryngeal injections.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD NOVEMBER 17TH, 1904.

Dr. JAMES BARR, the President, in the Chair.

EXTRACTION OF DOUBLE CATARACT.

Mr. THOS. H. BICKERTON exhibited a female patient

æt. 76, upon whom he had operated for double cataract. Cocaine was first tried, but the patient was so restless that the operation could not be undertaken. A few days later, chloroform was administered and double cataract extraction performed. An uneventful recovery followed, and an excellent result as regards vision had been obtained. Mr. Bickerton said this was the first occasion on which he had performed double cataract extraction at one sitting, and remarked upon the rarity with which it was necessary to administer a general anæsthetic for operations of this nature.

Dr. K. A. GROSSMANN congratulated Mr. Bickerton upon his pluck, and upon the admirable result obtained, but he considered double extraction at one sitting a very risky procedure, and mentioned a case in which he had seen most disastrous results follow.

Mr. W. THELWALL THOMAS read a note on the TREATMENT OF SO-CALLED CONCUSSION OF THE BRAIN. He referred to recent physiological research, which had demonstrated the absence of vaso-motor nerves in the cerebral arteries, the impossibility of producing any effect on the circulation of the brain by applications to the exterior of the cranium, the importance of the cerebral venous pressure, and the control the splanchnic vaso-motor mechanism exercised by acting indirectly through the general circulation. He divided concussion into three varieties: (1) simple concussion, merely a temporary disturbance of pressure equilibrium within the cranium, which is quickly recovered from; (2) severe concussion, which he considered to be simply shock; he deprecated the use of ice-bags in this condition, and mentioned cases in which the continued application of ice had perpetuated the symptoms, and recovery had quickly followed on changing the treatment; (3) Continued concussion, in which he considered contusion of the brain and meninges existed. In this condition unconsciousness quickly gave place to irritability, restlessness, mild delirium, &c. A sedative line of treatment was strongly insisted upon, and for this purpose morphia and chloral were greatly preferable to bromides. The importance of absolute quietness, tactful nursing, and the administration of free nourishment was emphasised. Free purgation was not recommended, as it interfered with rest. On returning consciousness, the administration of iodides was of marked value, many of the so-called after-effects of concussion—clouded intellect, loss of memory, and headache—being thus cleared up. So long as the temperature, pulse, and respiration remained normal, if the patient could be made to take adequate nourishment, the prognosis was good. Long-continued unconsciousness, with paresis, paralysis or coma, indicate cerebral laceration, and a rise of temperature without a corresponding quickening of the pulse and respiration, together with a loss of control of the bladder and rectum, generally indicate severe laceration, and the prognosis is consequently much more unfavourable.

Mr. Damer Harrison, Dr. W. Alexander, Dr. W. B. Warrington, Mr. Rushton Parker, Mr. G. P. Newbolt, Mr. E. M. Stockdale, Professor Sherrington, and the President took part in the discussion.

Mr. ROBERT JONES read a note upon SPINAL COCAINISATION,

which will be found in another column under the heading of "Original Communications," page 563.

Dr. WILLIAM CARTER read a paper on SOME OLD AND NEW REMEDIES.

The main proposition was that medicinal and other agents can often, in an unknown way, so modify cells and tissues as to make a diseased person sound, and not that they merely relieve symptoms, while Nature effects a cure. He illustrated this by mentioning cases in which prolonged and most serious illnesses were arrested and the patient cured by using such old remedies as the liquor sarsæ co. concentratus, mercurial inunction, and vinum antimoniale. He drew attention to the fact that the result of examining 25,500 recent prescriptions adopted in the "Extra Pharmacopœia" showed that not one of these substances was so much as mentioned. He contrasted the opinion expressed on the one hand by Boecker, and on the

other by the late Mr. Allanson, of Leeds, concerning the first of these drugs, Boecker simply dismissing it as useless, while Allanson thought highly of it though unable to explain its mode of action. Among other remedies, succinate of iron in biliary colic, and large draughts of pure water in renal colic, were mentioned, and their utility illustrated by cases. Reference was made to the useful effects on leucocytosis and chronic splenic enlargements by X-rays, and a photograph was shown of a very large and remarkable tumour of the face which was considered to be malignant by all the medical men who saw the patient. An operation for its removal had been recommended, but under X-ray treatment the tumour had, in a comparatively short time, entirely disappeared. Lastly, allusion was made to the contradictory opinions of Schmiedeberg and Ringer on the utility of aconite, the first asserting that "saving its value in neuralgias it can be relegated to the obsolete means of treatment," while the second states that "perhaps no drug is more valuable than aconite," and cases were mentioned showing the extraordinary benefit which the drug is capable of affording in certain conditions of the heart.

Dr. R. E. Kelly, Dr. A. G. Gillan, Dr. F. H. Barendt, Dr. E. T. Davies, Mr. F. Larkin, Mr. T. H. Bickerton, Dr. R. J. M. Buchanan, Dr. C. J. Macalister, Dr. N. Roberts, Dr. O. T. Williams, and Dr. K. A. Grossmann took part in the discussion.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 26th, 1901.

### TREATMENT OF VAGINAL GONORRHOEA.

THE treatment of blennorrhagia in woman, says Dr. Daniel, is a problem which has much occupied the practitioner. The difficulties of the treatment are derived, on the one hand, from the special anatomical disposition of the female genital organs, and on the other from the multiplication of the microbe of Neisser in the different segments of the uro-genital apparatus. By its canicular form, by its very oblique direction downwards and forwards, the vagina forms an organ difficult to disinfect. Between the folds of the mucous lining the microbes are concealed in chronic blennorrhagia; they seem to take refuge in these localities, from whence they are ready to reinfect the whole region.

It is true that Brumm denied the primitive infection of the vagina; the microbe would be found particularly in the glandular regions: the vulva, the urinary meatus, and also in large numbers in the os. If that be so it is none the less true that the vagina in gonorrhœa infection is the seat of intense inflammation, constituting the most common form of vaginitis.

In any case, the only way to treat and cure vaginal blennorrhagia scientifically is to attack the microbe where it is found. The treatment should consequently be both vulvar, cervico-uterine, urethral and, above all, vaginal.

In very acute cases at the outset, irrigations (6 quarts of boiled water or a solution of permanganate of potash, 1-10,000), associated with prolonged baths, will be sufficient until the acute stage has passed. At this period the following rapid treatment will be attended with remarkable results:—

(a) The whole region inside and out will be washed with soap and warm water by means of a vaginal brush or a piece of sterilised wool.

(b) Rinsing of the vagina with simple boiled water.

(c) Injection of six quarts of a warm solution of permanganate of potash, 1-4,000.

(d) Plugging of the vagina with five or six plugs of sterilised gauze impregnated with the same solution.

(e) At the end of twenty-four hours the plugs are withdrawn and the injection repeated as before, and followed by fresh plugging. At the end of another twelve or twenty-four hours the plugs are definitely removed.

Such is the treatment in its essential points. It is executed in two sittings at an interval of twenty-four hours. As to the results, in the numerous cases in which he had employed it, the absence of all gonococci was verified by the microscope.

During the following days the irrigation of the vagina by the permanganate solution will be continued two or three times a day (two quarts at a time) to prevent any possible return. At the end of ten or fifteen days, when the vaginitis will be cured, the disinfection of the vagina may be completed by that of the uterine os, the vaginal *cul-de-sac*, the vulva, and the urethra. For this it will be sufficient to paint the parts every two days with a solution of nitrate of silver, 1-100. As to the urethra, a pencil of the nitrate will be introduced and immediately withdrawn every eight days for about a month, when all infection will be removed.

#### TREATMENT OF OBESITY.

*Breakfast, 7 o'clock.*—Cold lean meat, two to four ounces; two drachms of bread, a cup of weak tea without sugar or milk. *10 o'clock.*—one egg without bread. *12 o'clock.*—Roast or grilled meat, two to four ounces without gravy or sauce, green vegetables *ad libitum*, without butter or grease, weak tea without sugar. *4 o'clock.*—A cup of tea without sugar. *7 o'clock.*—Two eggs, green vegetables, one ounce of bread, weak tea.

A walk of half an hour after the principal meals. In this way the patient will have lost twenty-four pounds in twenty-five days. At the end of that time the rigour of the *régime* may be lessened; the quantity of bread may be increased, and the tea may be replaced by a little wine and water, and a little butter may be allowed in the vegetables.

For some months the patients will continue to observe the *régime*, and finally they will have lost from forty to eighty pounds weight, by which the dyspeptic troubles, oppression, and bronchial catarrh from which they generally suffer will have been greatly relieved.

Such is the treatment recommended by Professor A. Robin.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 26th, 1904.

At the Medical Society, Hr. Baginsky showed an EXTREME DILATATION OF THE COLON, especially of the sigmoid flexure; along with the dilatation there was atrophy of the wall of this section of intestine. The disease was first described by Hirschsprung. The preparation was taken from a child, *æt.* 10 months, who was admitted with extreme meteorism, and died shortly afterwards. There was probably a congenital disposition to the abnormality. It was only when fecal stasis developed that the condition came about.

The speaker then proceeded to discuss

#### ACUTE RHEUMATISM IN CHILDHOOD.

He had observed a total of 139 cases of articular rheumatism in children. One of his assistants had already published an account of 73 of the cases; there remained, therefore, 66 to report on. Those cases of pure primary articular rheumatism only would be considered, not those in which the joint inflammation was secondary to other infantile disease. Amongst infants at the breast there was no case; between the ages of one and five there were 5; between 5 and 10, 32 cases; and 29 between the years 10 and 14. It appeared, therefore, that the greatest number of cases occurred at the age when the greatest increase in height was taking place, *i.e.*, between 5 and 7 and 11 and 14. His statistics did not show that the disease was more frequent during the colder parts of the year, as 24 cases were admitted in the winter months and 42 in the summer. It could not be determined that heredity played any part, as after inquiries showed that only seven of the patients had

suffered from the disease. In spite of this, however, observation in private practice gave him the impression that hereditary disposition was of importance.

An initial angina, the importance of which had been over-rated, was present only in nine cases.

He distinguished two principal groups of the disease of which one passed off quickly and was readily amenable to treatment, while the other was a malignant form, and ran its course either rapidly or led to cardiac complications, which then became the prominent feature. Both forms might have a strong commencement.

Examination of the blood was mostly negative—nephritis appeared rarely, but chorea on the other hand frequently. At one time various serious complications on the part of the central nervous system were described, but he believed that such cases were really cases of cerebro-spinal meningitis. Chorea developed in a third of the cases. In spite of this, however, chorea minor could not be considered as a rheumatic affection as it came on when there was no rheumatism, and then no explanation could be given for its occurrence.

The occurrence of endocarditis in the course of a rheumatic attack was of special importance. The heart remained intact only eight times, 17 were left after subsidence of the cardiac mischief with an apparently healthy heart, 35 were discharged with unsound heart, and 6 died.

Pericarditis had been of special interest to him. He exhibited a series of curves and diagrams which showed the importance of this disease in relation to the course of the cases; most of the cases ended fatally.

He then showed a number of preparations—widely dilated hearts, the enormous dilatation of which flat-sided or band-like, could not be explained by the endocarditis, but by pericarditis. If children got over the pericarditis for the time, they almost, without exception, died from it during puberty.

In rare cases the articular rheumatism of childhood might become chronic, leading to ankylosis of most or even all of the joints.

Therapeutically, since the introduction of salicin, only one thing had changed, the articular diseases could be treated with success. As regarded cardiac disease, we were as powerless as before. The only things that had proved of any value out of the great array of remedies were ice and potassium iodide.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 26th, 1904.  
GALE NORVEGIENNE.

AMICIS relates a peculiar case of itch, or "gale Norvégienne," as he is pleased to designate it, in the case of a child that had come under his care. Why he calls it Norwegian itch is not so easily explained, as the patient was an Italian from Naples, *æt.* 13 rachitic and greatly emaciated.

The whole surface of the body was red between the large rupia crusts universally spread over the skin, resembling in every detail psoriasis universalis. The diagnosis might have been more difficult had Amicis not had the father previously under his care for scabies. On examining the crusts on the child the sarcoptes scabei, or Bergh's acari, was discovered by the microscope, which confirmed his opinion of its being the Norwegian disease.

#### HYDROPHOBIA AND INOCULATION.

Heydenreich tells a fine story of how two persons were bitten by a dog which was supposed to be mad. To confirm the opinion the dog was taken to a veterinary surgeon and duly killed, but, strange to say, no *post-mortem* examination was made of the dog, nor the membranes of the brain. Pasteur's preventive lymph was inoculated in one of the cases, while the second refused the "saving grace."

After the inoculation, the patient, who had every confidence in the wisdom of his medical man, was taken ill with a high fever, great pain in the bowels with intractable constipation. Shortly after this, paralysis, with a severe form of psychosis, made its appearance.

At this stage of the disease Heydenreich saw the patient and declared that some mistake had arisen, as the whole train of symptoms were not in accord with the recognised descriptions. The mad dog was exhumed and examined, but no condition of the membranes could be found resembling "wirt." It was therefore concluded that the symptoms were due to the lymph and not to any poison from the dog, as the second party bitten by the dog, who refused the treatment, remained perfectly well, and smiled at his fellow's credulity!

#### HEMATIC CONCENTRATION AND NEPHRITIS.

Loeb and Adrian have recently been experimenting with the molecular concentration of blood and its effect on the kidneys. They find that it is only in bilateral nephritis that this concentration of the blood takes place. Blood freezing at the normal point, therefore, may cause functional disturbances, or morbid conditions of the renal tract anywhere in the kidney affected, but never when both kidneys are involved. He considers this test pathognomonic of bilateral nephritis, and easier applied than testing the urine from the individual ureters.

#### THERMOPALPATION.

Sommer in his investigations reveals a state of temperature which may have some bearing on the therapeutics of the ear. In using Herz's thermopalpation instrument he has come to the conclusion that both of our ears have not the same temperature; that the left ear cavity has a higher temperature than the right. The difference is not great, but sufficient to be distinctly observed by the instrument. He concludes that this high temperature is due to a more active condition of the left side of the brain, where the circulation is greater in the left hemisphere than the right.

#### SYPHILIS AND MERCURIAL VAPOUR.

Welander, of Stockholm, writes to the *Wachenschrift* his experience of the vapour treatment of syphilis in females, which he prescribes in measured quantities for inhalation. He finds this form of administering mercury admirable for children suffering from hereditary syphilis. The urine must be carefully watched for albumin and cylinders, which frequently supervene. This treatment requires special wards, which have now been in existence in that city for the last four years, and have been instrumental in saving many children that would have inevitably died if left in their own homes. In Sweden syphilis is not so widespread as in many other countries, as all persons so affected are taken into hospital and carefully treated till all trace of the disease has disappeared. This is one of the causes assigned for the low number of cases to be found in that country.

#### ACNE VULGARIS.

Söllner finds a large number of micro-organisms in acne vulgaris, but there is not one among the number that could be cited as the etiology of the disease.

#### IS TUBERCLE INHERITED?

Schmorl and Zeipel have devoted a great deal of time to the examination of the placenta in order to determine the absence or presence of tubercle in membranes of the offspring. They give a long history of twenty cases. One of miliary tuberculosis, one of tuberculous meningitis, eleven of advanced tuberculosis, four of fully developed and three of incipient pulmonary tuberculosis. In nine of these cases tuberculous changes were present in the placenta. It requires careful manipulation to discover the morbid product, as may be inferred from 2,000 sections being necessary in one case. The tuberculous centres are usually located to the outer shaggy surface or the inner; more rarely on the decidua basalis, and least of all on the broad chorial surface of the placenta. By this it is argued that tuberculosis can be directly transmitted without infection at all.

## The Operating Theatres.

### ST. PETER'S HOSPITAL FOR STONE.

#### REMARKS ON LAST WEEK'S CASE OF PROSTATECTOMY.

—Dr. THOMPSON WALKER pointed out that the questions of practical importance in regard to prostatectomy are: What is the risk of the operation? How long will it be before the patient is well? And what are the after results? He said that recently (*Practitioner*, August, 1904) he had collected 83 cases of suprapubic prostatectomy by various surgeons and found that the total death-rate of the operation, both immediate and during convalescence, was 10.8 per cent. This included some cases in which the fatal result was not directly due to the operation, but as it occurred before the patient was completely recovered from the operation these deaths had to be counted as part of the mortality of the operation itself. Taking this death-rate as it stands it is an astonishingly low figure; for it must be remembered that the average age of these patients was 65 years and 8 months, while 22 of them were over 70 years of age, and 79 per cent. of this total number of cases were over 60 years. On tabulating the ages with the deaths he found, however, that the risk did not increase with the age. The risk is, of course, greater where advanced kidney disease, bronchitis, or such complications are present, but even in such cases the patient need not be refused operation, for many of the successful cases had been suffering from these and other serious complications. When this mortality is compared with that of other operations of equal gravity, it will be seen to be very small. The duration of convalescence varies a good deal. A few cases may be healed and out of the surgeon's hands in three weeks, but some take double that time. The average is, he thought, about four or five weeks. By this time the suprapubic wound is healed, and the patient is well enough to leave the surgeon's care. The recovery of vitality and general health in these patients is remarkable, and it is the more striking the more depressed the general condition was before the operation. The risks of the operation extend, however, through the whole course of the convalescence, and there are few operations he knew of in which the anxiety of the surgeon is more prolonged. In the series of cases he collected, death occurred as late as the twentieth and twenty second days after operation. In a case of his own the patient progressed without any unfavourable symptoms, except delayed healing of a very thick abdominal wall, until the end of the fifth week, when he began to lose ground, and died six weeks after the operation, apparently from septic absorption. The complication of sepsis he considered to be one of the most important the surgeon has to fear, and it is difficult to guard against, for many of the bladders operated upon are in a state of chronic cystitis and the urine is foul. Prolonged preparation by bladder washing previous to the operation is not always possible, although it is very important in these septic cases. Nor is it always effectual, for the bladder often contains pouches and calculi may be present. Urethral drainage through a catheter is imperfect, and perineal drainage is little better. Suprapubic cystotomy in such cases is attended by too high a mortality to be lightly considered as a preliminary measure. He thought the best preparation was prolonged careful bladder washing

by the urethra. The after-results of prostatectomy as it is now practised in this country are very surprising and completely controvert the statements of the great surgeons of the last generation, that the bladder function was destroyed and would not be regained even if the obstruction were removed. These patients retain their urine as long, and pass it in as powerful and free a stream, as they did before the prostate began to obstruct the outlet of the bladder. The result of the operation is therefore perfect. There is no incontinence, no fistula, and there is no stricture. The two former sequelæ may be noticed in the records of cases done by the perineal method. He referred especially to the cases reported by Continental surgeons, who have told him personally that such results are far from uncommon. The possibility of stricture has been more than once raised as an objection to this operation. Experience has shown that such fears are groundless.

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### The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 30, 1904.

#### THE ANNUAL MEETING OF THE ROYAL COLLEGE OF SURGEONS, ENGLAND.

THE times have changed at the annual meeting of the Fellows and members of the Royal College of Surgeons, England, as may be gathered by the fact that on the 17th inst., when the meeting was held, the proceedings had to be suspended in consequence of the necessary quorum not being present. As far as we are aware no such incident has ever occurred before; on the contrary, the occasion has always been one on which many members have availed themselves of the pretext to visit their College, and by their presence support those who had made themselves the leaders of what used to be known as "college politics"; there is, however, no gainsaying the fact that at the present moment so-called "college politics" are at their lowest ebb. The Association of Fellows, which represented the Reforming body of Fellows, has ceased to exist; and the Association of members, if it has now any political existence, is not taken

seriously; and thus it has come to pass that despite the fierce engagements which in former years took place between the Council and the "body corporate" the lapse of time has converted the sword into the ploughshare, and the Council reigns serenely as of yore, secure in its traditions and just as unassailable. Still, it is interesting to recall that the present President owed to the suffrages of the Reforming body of Fellows his first election into the Council. At the time in question he was an active member of the former and lost no opportunity of impressing upon the Council the necessity of granting concessions in favour both of the Fellows and members. It was soon after his election that the career of real political importance of the Association of Fellows began. Its candidates at the annual election of members of the Council were then nearly always successful; the Association, in fact, had attained a degree of organisation which constituted it a real menace to the old time conservatism of the Council. The Council were thus compelled to recognise its political importance, earnestness, and influence, and then it was that certain reforms were granted from which the Fellows have since benefited. So far, however, as the meeting on the 17th instant is concerned, we are glad to note that the business transacted thereat consisted of several important matters apart from college politics. Nothing, for example, could have been more in keeping with the character of the meeting than the resolution moved by Dr. Danford Thomas, having reference to the relations of the medical profession to the Coroners' Courts. It is unnecessary to point out why this has become such a burning question of the day, inasmuch as the facts are notorious in connection therewith. Nevertheless, when the matter was referred by the London County Council to the Council of the College no steps were taken to prepare an exhaustive report thereon, nor was any authoritative attempt made by the latter to indicate the strong feeling which existed in the profession against the irregularities which had occurred in one particular Coroner's Court. We entirely agree with Dr. Danford Thomas that the Council of the College, instead of acting in an invertebrate manner, would have done well to have arranged an independent inquiry into the matter with the assistance of some Fellows and members having intimate knowledge of the subject. We hope that even now some means may be found by which the College, may exert its influence by the expression of an authoritative opinion upon the irregularities which have occurred. As a member truly pointed out according to Bye-law XV. of the College the College promises at all times to protect and defend the Fellows and members in the exercise of their rights, and in our opinion this is precisely the occasion on which the Bye-law in question might usefully be carried out.

#### THE HOSPITAL FUNDS AND THE SMALL HOSPITALS.

NOT unnaturally the publication of our recent



leading article dealing with the policy of the Hospital Saturday, the Hospital Sunday, and the King Edward's Funds towards the small metropolitan hospitals has attracted considerable attention. Our main contention was to the effect that whereas the institutions in question were supported by the Saturday Fund that many of them, on the other hand, sustained serious damage in loss of prestige and of income, owing to their non-recognition by the other two of the above-mentioned funds. The Editor of the *Hospital*, an acknowledged authority in the world of medical charity, has entered a temperately worded tentative protest against our position and has asked for a list of excluded small hospitals. He points to the fact that the grants to the thirty-three small hospitals have materially increased during the past few years. That argument by no means disposes of the claims of the small hospitals that happen to be outside the charmed circle of favoured institutions. It is much the same as saying that because the Registrar-General has devoted more care to the statistical returns of the thirty-three great towns of England and Wales, therefore other insignificant towns left out in the cold should rest and be thankful. We venture to suggest to Sir Henry Burdett, however, that the alleged injury to the small hospitals not included among the recipients of grants from the King Edward's and the Hospital Sunday Funds is in no way mitigated by his pointing to the thirty-three small hospitals that have been so favoured and recognised. Indeed his statement merely serves to emphasise the inequality of distribution and to invite an inquiry into the principles that prompt the Committees in making their awards. In an early issue we hope to furnish Sir Henry with the desired list of small hospitals that have been excluded from the benefits of the two Funds in question. Meanwhile it is only fair and right that the public who contribute the money should be fully and exactly informed as to the precise principles upon which the grants are allocated. So far as it is possible to form a judgment from results the wisdom of the controlling Funds is not altogether self-evident. Take the case of the Royal Orthopædic Hospital, which until recently stood upon an enviously valuable site in Oxford Street. Some years ago the then executive, under the chairmanship of Sir Walter Gilbey, wished to sell the site; but their scheme was not approved by the Governors, and Sir Walter was succeeded in the chairmanship by Mr. H. H. Marks, the well-known financial magnate and now M.P. The newly-elected executive again determined to sell, and that course was urged by the Sunday Fund in the most forcible way at their command—namely, by withholding a grant until amalgamation or sale of the Royal Orthopædic Hospital had been effected. Meanwhile the opponents of the scheme for sale did not relax their efforts, and although they did not succeed in preventing the sale, they nevertheless raised the selling price by no less a sum than £12,000. Now the Sunday Fund had urged the Hospital to sell at the lower price, so that if the advice of the Fund

had been followed twelve thousand pounds would have been lost to the charity. Now we think the public is entitled to know on what grounds the Hospital Sunday Fund urged the sale of the enormously valuable site in Oxford Street, not only at the lower price, which was clearly far under the actual value, but at any price at all. What ordinary citizen of any business capacity would have dreamed of parting with a valuable freehold in order to spend the purchase money in building another hospital on leasehold property elsewhere? We are entitled to ask if the Hospital Sunday Fund, before assuming this great responsibility with regard to urging the sale of the Orthopædic Hospital premises, made itself fully acquainted with the arguments of the minority opposing the sale. There is no need to remind Sir Henry Burdett of the history of the dispute in question, with the details of which he is already acquainted. We should be glad to hear his explanation of the part played by the Hospital Funds in the sale of the Royal Orthopædic Hospital site. We shall be also glad to learn what evidence was taken for and against the proposal. In short, this case may be taken as a preliminary opening up of our inquiry into the methods that control the Hospital Funds. His Majesty King Edward, as we said on a previous occasion, will be the first to insist upon the correction of any inequality of administration that may be revealed. We may commend to his gracious consideration as a first step towards security of justice the proposition that every hospital, regardless of its size, should be represented upon his own and upon the Hospital Sunday Funds, as in the case of the Saturday Fund.

### Notes on Current Topics.

#### Spinal Anæsthesia in Labour.

SINCE the fall of our first parents it has been the lot of womankind to bring forth children only at the cost of much suffering to herself, and the inventor of a method by which that process could be accomplished without pain would deserve, and probably receive, the benediction of a host of mothers. Martin has been trying whether the production of local anæsthesia by spinal cocainisation would not be as serviceable in labour as it is reported to have been in a large number of surgical operations. In all he has employed the method in thirty cases, his usual plan being to inject a centigramme of a 1 in 2,000 solution of adrenalin into the subdorsal space, and to follow this five minutes later by a solution of cocaine. The effects were not all consistent, but although marked variations occurred in the duration of the action of the drug, in twenty-nine cases good anæsthesia was obtained. In nine of these cases it lasted only half an hour, but in most of the others it persisted from one to three or even four hours. When labour came on within an hour or an hour and a half after the injection, the pains were but little felt by the mother, but in all cases the uterine contractions were retarded, and the patients used their abdominal muscles only when urged to do

so. The majority of the patients had marked vomiting and nausea after the injections, an effect that was not counteracted by the subsequent injections of caffeine salicylate, as Martin had expected. This, however, seems to have been the worst that happened, for the puerperium was not disturbed and milk secretion was natural. Martin, at any rate, is so far pleased with his plan that he proposes to continue it in further cases where chloroform is inadvisable. We should be glad if he could so far perfect the operation as to make the birth of a child no more of a burden to a healthy, civilised woman than it is at present to a negro woman in Central Africa; but we fear that such a consummation is more to be wished for than expected.

#### Figs as Physic.

THE generous amplitude with which the British Pharmacopœia is recruited from the vegetable world is recognised mainly by students of therapeutics. From every quarter of the globe, from every herb that bears fruit and those which do not, some active principle may be obtained, if only man's ingenuity can find it out. Many of these products, from the stately tree of the forest to the humble weed that flourishes in the ditch, are of distinct use "for the healing of the nations." The therapeutic value of the fig has been recognised from remote ages. As an article of food it was largely used by both the Greeks and the Spartans, while an alcoholic beverage prepared from the fermented fruit was known to Pliny under the name of *scytis*. The so-called seeds, which are in reality the fruit proper contained within a fleshy receptacle, have long enjoyed a reputation as a mild laxative, and to this day the fig itself, green or dry, or syrupy preparations thereof, are consumed with this object. It is somewhat strange, however, that this popular remedy only receives the sanction of the Pharmacopœia as one of the ingredients of that most comfortable electuary, *Confectio Sennæ*. The receptacles when cut open act admirably as a cataplasm, the knowledge of their heat-retaining properties as adapted to the treatment of boils being at least as old as the days of Hezekiah. In virtue of the sugar which they contain, such an application would be quite as antiseptic, if not more so, as the more familiar linseed-poultice. A syrupy extract of figs has also been recommended as a demulcent in certain irritable affections of the throat. The juice from the stems and leaves of the *Ficus carica* is acrid and it has been employed to raise blisters. The fruit enters largely into the dietary of the nations of Southern Europe, and an attempt is being made in certain quarters to institute a "cult" for the more general consumption of the fig in this country.

#### Weight-carrying and Growth.

THE adaptation of the skeleton to the strain imposed upon it while lifting or carrying heavy burdens is no less surprising than the amount of muscular strength exhibited by those who are daily accustomed to such tasks. Physical endur-

ance is by no means invariably commensurate with great muscular development, but there is no disputing the fact that feats involving Herculean strength can only be performed by persons whose muscular tissue is powerfully knit together. Mere bulk alone is, of course, no criterion whatever of muscular strength, as may be readily proved in the case of that curious affection, pseudo-hypertrophic paralysis. It is the fitness of each individual fibre and its ability to contract co-ordinately with its fellows in response to its owner's commands which constitutes real muscular efficiency. As far as lifting heavy weights is concerned, everyone knows who is accustomed to such work that there is a good deal in getting hold of the load in the right manner and also in the method by which it is supported by the body. In other words, knack is almost as important as muscular strength, a fact to which any railway-porter can testify. The head and shoulder are the best anatomical sites for weight-carrying, and it has been shown that characteristic bony change may ensue after an individual has been engaged in this work for a number of years. The worst position is that in which the weight is held in front of the trunk and the body consequently bent backwards, the head being flexed. A good deal of strain is thus imposed upon the abdominal muscles, and if the abdominal rings are abnormally patent there is a risk of a hernia coming down. The dwarfing effect of weight-lifting upon young girls was dwelt upon by Miss Anderson, Chief Lady Inspector of Factories in her evidence before the Physical Deterioration Committee. Heavy lumps of clay are sometimes carried by girls in their teens, and loads of fruit are similarly borne in certain jam factories by young women. It is most desirable that a general maximum of weight that may be handled by young persons should be legally established for all industries alike.

#### Light as an Anæsthetic.

ONE might have been pardoned for believing that most of the uses of light had already been explained within recent years. Red light, white light, the ultra-violet rays, and so on, each was stated to have its own sphere of usefulness in therapeutics or in diagnosis. If we are to put faith in some recent reports, however, blue light has a peculiar power of its own, in that it is said to produce anæsthesia. Professor Redard, of Genoa, has published several cases in which he states that he produced brief periods of excellent surgical anæsthesia by the simple device of making the patient fix his gaze on an intense blue light. The apparatus used is simply an electric arc lamp enclosed in a blue globe, and fixed in a blue polished reflector. The patient's head is covered by a blue cloth in such a way as to shut out all rays of light but those coming from the lamp. He is instructed to keep his eyes open and fixed on the light, and Professor Redard states that in two or three minutes the pupils become widely dilated, and anæsthesia exists. It persists long enough to permit of such an

operation as extraction of five or six teeth, and the patient is quite unconscious of what is being done. Redard does not regard the phenomenon as hypnotic, for he has failed to produce it by suggestion, or by the use of any other light than blue.

#### The Cause of Rabies.

It is curious that some of the diseases in regard to which we have been most successful in the production of artificial immunity depend on causes of which we are still ignorant. This is true both of small-pox and of rabies, for although in the investigation of these diseases many bodies have been given by their discoverers a causal importance, yet up to the present there is no general agreement in either case. In regard to rabies, most interest at present centres round the researches of Dr. Legri, of Pavia, who last year described certain bodies found in the nervous system of animals dead of rabies. The bodies are round in shape, and vary in size from what can be just seen with the highest power of a microscope up to a diameter of twenty-five microns, the average size being four to ten microns. They were found in all parts of the nervous system, and can be demonstrated by the ordinary stains. Legri himself found them present in fifty out of fifty-two cases examined, while he has never seen them in any other condition than rabies. His observations have been confirmed by several Italian investigators of repute, and though the case is far from proven, yet there is on the face of it nothing against Legri's belief that he has discovered the organism of rabies.

#### A Hospital for the Insane.

VERY slowly, but it may be hoped surely, the idea is beginning to filter into the minds of administrators of the Lunacy Acts that a mentally-affected man is not merely a useless unit in society for whom a pigeon-hole has to be found to keep him out of harm's way, but a sick person who needs treatment. The accurate diagnosis of mental cases is as important as that of physical ones, and the consequent classification with a view to remedial treatment should be the foremost consideration in all lunacy administration. The chief function of diagnosis should be to separate the curable from the incurable, and the former should be considered so distinct a class from the latter that they should have no communication with them in the asylum. The ideal arrangement would be to have the patients susceptible of cure housed and looked after in separate establishments, but though it will be necessary to wait long to see such a desirable consummation, we are glad to note in the report of the Asylums Committee of the London County Council that a step in the right direction is to be taken. At the Bexley Asylum it is proposed to build a "villa," containing accommodation for fifty male patients, where cases capable of amelioration or cure will be placed, and from which any patient deemed incurable will be drafted to the main asylum. Already a similar villa is in working

order on the female side, and the arrangement has proved most beneficial, for it has proved that the bulk of the new cases need never enter the asylum proper at all. After discharge from the hospital villa cases will be transferred to a convalescent villa, and kept there till able to re-mingle with their sane fellows in the world once more. Hospital as opposed to asylum treatment of mental diseases, especially for mild and curable cases, will be a great advance, and hand in hand with it should go increased facilities for the study of mental diseases. The Asylums Committee of the London County Council are certainly waking up; it may be hoped that they will not be tempted to turn over and go to sleep again.

#### Repetition of Prescriptions.

WE have at various times commented on the danger to the public which is the result of the undue repetition of prescriptions. To cite no other example, it is obvious that the presenting time after time of an old prescription may make the path easy for the victim of a drug habit. In order to attempt the solution of a problem which not only by medical men but by pharmacists is recognised to be urgent, a conference has recently been held between representatives of the British Medical Association and of the Pharmaceutical Society. It is to be hoped that a friendly discussion of this sort will lead to some settlement agreeable both to the physician and the dispenser. In the meantime, certain suggestions are to be sent for consideration to the divisions of the British Medical Association, which, if adopted by a large body of the profession, and supported by dispensing chemists, will go far to check the evil. They are that every prescriber should signify in his prescription the maximum number of times it may be prescribed, and that he should also sign it with his full name and address. Any real solution must depend, however, on the hearty co-operation of the pharmacists throughout the country with the medical profession.

#### Detention of Medical Witnesses.

THERE are few medical men who have not, time and again, been dragged into court to give evidence in a case for a fee of a few shillings, and been kept waiting for many hours during which their ordinary work was urgently demanding their presence. It is, of course, inevitable that medical men, as part of their duty to the State, should give evidence in criminal cases, but they have a right to expect that the State in return will consider them and their patients in every possible way. Such, unfortunately, is far from being the case. The object of solicitors is to have their case ready and their witnesses present in good time, and the language in which subpoenas are couched makes the absence of any witness so serious an offence that it is generally unwise to risk not being available when a case is called unexpectedly. But the want of thought in this matter on the part of many solicitors often amounts to an abuse of their powers, and we

are glad to see that Mr. Justice Grantham warmly espoused the cause of professional witnesses at the recent sessions at the Old Bailey. The Judge said that he had received many complaints from medical men about the way they were summoned day after day when their services were not in the least likely to be required, and he was bound to admit that in his opinion the complaints were well justified. Cases, he said, were put into the lists when there was no chance of their being called, and the medical men engaged were kept kicking their heels about the court at great detriment to themselves and their profession. He impressed on counsel the duty of keeping the clerk informed of the length of time cases were likely to last, and on solicitors of finding out when their cases would be reached, and on both the importance of obviating inconvenience to medical men. It is refreshing to hear of a judge standing up for the much-trying doctors, and we hope his words will be taken to heart by the officials of other courts besides that in which they were spoken.

#### Repeated Rupture of the Uterus.

THERE is no accident occurring in child-birth which is regarded as more serious than rupture of the uterus, especially when it is complicated by passage of the child into the peritoneal cavity. It is luckily a rare occurrence, and does not happen if the patient is under proper observation. When it does occur, however, prognosis is bad for both mother and child. The child usually dies immediately, and the mother is likely to succumb to the effects of hæmorrhage and shock, or, if she rally from them, to general peritoneal infection. A case recently reported, therefore, by Patz, of Vienna, is all the more remarkable in that rupture occurred twice in the same woman, with an interval of five years, and the patient still survives. On each occasion a laparotomy was performed and a dead child extracted, and the uterine wound repaired. The first rupture took place in the anterior wall of the cervix and vagina, and the second through the posterior wall, the old scar remaining firm. The woman had a contracted rickety pelvis, and in order to prevent her increasing her already remarkable record, Patz accompanied his second operation by a hysterectomy.

#### Revivalism.

THE curious wave of revivalism that is now passing over some parts of South Wales illustrates the power of personality in a remarkable fashion, especially when that personality is animated by an intense and conscious prepossession. A Mr. Evans Roberts, a young working collier, is conducting a series of services in various villages at which extraordinary manifestations of enthusiasm and loss of self-control are witnessed. The audiences assemble long before the appointed time of meeting, and immediately the doors open the chapels are crammed to suffocation. Hymns, prayers, and addresses from Mr. Roberts go on for hour after hour, till strong men fall on the floor,

confess their sins, and weep on each other's necks like women. Some of these meetings last half the night, and others begin at three in the morning. Everywhere the same excitement prevails, and there can be no doubt about the depth of the impression produced at the time. The interesting point is that Mr. Roberts himself is by no means a good speaker; many of his hearers are known locally to be far better orators. Moreover, usually the key-note of his meetings is said to be merriment, Mr. Roberts smiling as he prays, and laughing as he preaches. But he has a vivid idea of his mission, and believes himself inspired by a Supreme Being "which put its hands on his shoulders and bent him double till the blood rushed to his head." The imitative influence of many hysterical affections is illustrated in this particular instance by the fact that at one meeting he fell on the floor whilst praying and continued his supplication in the prone position. One after another his audience proceeded likewise to fall on the ground and begin praying aloud. The psychological disposition of a crowd is an interesting study, for the effect of suggestion is much more easily seen in a mass of people together than in a single individual, and the power of affecting crowds of people till they lose self-control is given to but few individuals. One thing certain is that Mr. Roberts' campaign cannot go on for ever, and his health is sure to be undermined by these long drawn-out periods of excitement and abstinence from food, whilst there are worse dangers than mere bodily fatigue likely to be incurred by those who attend revival meetings.

#### History of Syphilis.

SOME interesting information is brought together by Dr. Knott, in the current number of the *Dublin Journal of Medical Science*, with regard to the early history of the disease and the word "syphilis." He tells us that the word was first used in 1530 as the title of a poem by Hieronimo Fracastorio, a native of Verona. This astonishing poem, which describes what was then thought to be a new disease, fills a quarto book of thirty-six leaves, and is highly praised by many critics from Scaliger to Dr. Knott himself. The latter is not a believer in the doctrine that syphilis was first introduced to Europe by the sailors of Columbus, and he brings much evidence to show that it existed long before, though there is no doubt, of course, that its great prevalence in modern society dates from the Siege of Naples in 1494. From its devastation of the French army at that time it obtained the well-known name "*morbis gallicus*," though the French themselves called it "*morbis neapolitanus*." Indeed, there were many national names given to it in different countries, as, for instance, "Spanish itch," "German," "Polish," "Turkish," disease, while the Turks responded with the name "Christian disease." From its similarity to the physical affection of Job, it has been known as "*morbis sancti Jobi*," and certain saints—St. Mevius, St. Roch, and St. Lementius—have also had the discredit of giving it a name.

### Occupation Pains.

It is noteworthy that many symptoms of disease and even some physical signs are causally associated with certain occupations. The more or less continuous assumption of a particular attitude, as writing, sewing, or digging, or the habitual exercise of the same group of muscles, as in handling certain tools, cannot fail, after a time, to leave its mark upon the body and some times even upon the bony skeleton. This latter point has been elaborated by Mr. Arbuthnot Lane, who has found that considerable changes may and do occur in the osseous framework of the body as a result of an alteration in the manner in which lines of force are transmitted through one of its segments. These changes are chiefly of anatomical and pathological interest. From the subjective point of view pain of some kind or other is nearly always a prominent feature wherever there is unnatural or persistent strain to be borne. The stooping posture at work is one of the commonest deviations from the normal, and whether the patient be a seamstress or a coal-heaver, a city clerk or a market-gardener, each and all are liable to suffer from a twisted chest and a crooked back. Among resulting ills are dyspepsia, a tendency to bronchial troubles and phthisis, backache, sciatica, and lumbago. Different occupations must necessarily give rise to varied symptoms which are due to the particular kind of work undertaken. The expressions "occupation-neurosis" and "occupation-dermatitis" are in common use, but we do not hear so much about "occupation-pain." Dr. James J. Walsh, of New York, read a paper upon this important subject before the recent meeting of the State Medical Association, in which he stated that many of the aches and pains in reality caused entirely by the individual's work were erroneously supposed to be due to chronic rheumatism. The fact remains, however, that the majority of such pains are decidedly aggravated by cold and damp.

### Hygiene as She is Wrote.

THE desirability of including teaching in the elements of hygiene to youngsters in elementary schools has been considerably to the fore of late, and it is encouraging to know that in some schools instruction is already being given. But it is one thing to give instruction and another to receive it, and the examiner is likely to be relieved of a good deal of the tedium that usually attaches to his office if pupils in general are as naïf as those whom Dr. Newsholme recently had the pleasure of testing in hygiene and first aid. One boy had so firmly grasped the principles of sanitation that he was able to reply to a question that "the best way to avoid danger from impure water in the cistern—is to have water from the main sewer in the road in front." Such a youth ought to run but little risk of typhoid fever in after life. The treatment of dog-bites seems to have taken a firm hold on the pupils, and amusing as the answers are, they point to instruction of a somewhat archaic type having been instilled into the young brains. "It should

be burnt out with a cosmetic," wrote one hopeful—a procedure a good deal more humane, and not much less appropriate than the one he intended to describe. A laconic fellow-student answered the same question with "Red-hot poker," without mention of extenuating circumstances. His teacher must, we fear, have been of what the homœopaths call "the old school"; at any rate one would be inclined to give both teacher and pupil a wide berth if one happened to have been bitten by anything but a very rabid dog. But the answer at once most humorous and least open to cavil was that of a young gallant, more circum-spect than altruistic, who suggested, "If any person is found handy and foolish enough to suck the bite, let it be done." There is a fine air of detachment about this, which makes us fear that the spirit of the Good Samaritan had not imbued the little author with the nobility of his calling.

### A Parisian on American Surgery.

DR. FAURE, the well-known Paris surgeon, has recently paid a visit to America, and on his return to France has published the result of his observations. He was particularly astonished at the magnificence of some of the operating-rooms in the New World, and he mentions the Mount Sinai Hospital, New York, as the handsomest he has seen. Both walls and ceiling are formed of single sheets of white marble, and M. Faure naturally regards such opulence rather as a mark of prodigality than as justifiable expenditure. The number of assistants and nurses present at an operation—three or four of each—is in contrast to what obtains in France, where the surgeon aims at performing his work with the aid of only one assistant. What seized M. Faure's admiration more than anything else was the excellent and intelligent nursing across the Atlantic. The American nurse is usually a young woman of good education and social standing, quite different from the French *infirmière*, and tasks are entrusted to her which in Paris are the duty of the *internes*. American surgical instruments appeared clumsy and coarse to one used to the neatness of the hand-made articles in use in France. While M. Faure, like another observer, thinks that there are some matters they order better in France, yet he is, on the whole, an appreciative critic of American surgery.

### Carbonic Oxide Poisoning.

THE risks run by factory workers in lime kilns, cement works, and other places where braziers' and coke fires are employed in confined spaces from the inhalation of carbon monoxide are notorious. Milder degrees of poisoning by that gas, however, are often overlooked. Insufficient ventilation of workrooms and defective gas-fittings, for instance, whereby small quantities of the gas are continuously and imperceptibly inhaled for many hours daily, induce a condition of chronic anæmia which in its turn leads on to something worse. A memorandum upon the use of water-gas and the consequent danger of

poisoning by carbonic oxide has been issued by the Chief Inspector of Factories. In the annual report of the Factory Department during the five years 1899 to 1903 fifty-one cases of poisoning by water-gas are detailed. Seventeen of these were directly due to carbonic oxide, while thirty-four were due to gases of a similar nature, such as those of Dowson and Mond, employed for heating furnaces, boilers, and for other industrial processes. Many different causes contributed towards the casualties, such as ignorance of the nature of the gas, cleaning of flues before a sufficient time had been allowed for the gas to escape, lack of rescue appliances, and so on. It is recommended that notices of warning be posted up in factories and workshops where any danger of this nature exists, and it is to be hoped that the instructions contained therein will be carefully followed. The value of a knowledge by the master and foremen of a factory of the principles of first aid, especially of the methods of performing artificial respiration, should certainly be more fully recognised, as it is only by the prompt application of remedial measures that life can be saved. The stability of the combination of carbonic oxide with hæmoglobin is well known to chemical physiologists, and this being the case there is all the more urgent need for immediate and energetic treatment.

#### PERSONAL.

DR. C. THEODORE WILLIAMS will preside at the Sixth Annual Dinner of the Medical Graduates' College and Polyclinic, to be held at the Trocadero Restaurant, London, on December 7th. Further particulars can be obtained of the Hon. Sec., Mr. A. E. Hayward Pinch, F.R.C.S., 22, Chenies Street, W.C.

PROFESSOR ARTHUR THOMSON, M.B., who holds the chair of Human Anatomy in the University of Oxford, last week formally took his seat on the General Medical Council as representative of this University.

AT the same meeting of the General Medical Council Dr. A. G. Barrs was introduced as the member representing the University of Leeds for three years from October 19th, 1904.

DR. ARTHUR G. BOYCOTT, Fellow of Brasenose College, Oxford, Gordon Lecturer in Experimental Pathology at Guy's Hospital, has been appointed Assistant Bacteriologist at the Lister Institute of Preventive Medicine.

SIR JAMES RECKETT has made a handsome donation of £6,000 to the Hull Royal Infirmary for the purpose of completing the extension of the buildings of that Institution.

THE Lady Cheylesmore, Mayoress of Westminster, has kindly consented to open the new building of the Royal Ear Hospital, recently erected in Dean Street, Soho, on Monday, December 12th, at 3 p.m.

DR. L. V. DUBOIS, Government and Poor law Medical Officer of Pampléousses, Mauritius, has been appointed Government Medical Officer, Savanne. Dr. L. de Boucherville takes the place of Dr. Dubois at Pampléousses.

PROFESSOR FRANCIS DIXON, M.D., delivered an address on the "Distribution of the Peripheral Nerves" at the opening meeting of the Dublin University Biological Association on Thursday last. Amongst the speakers who followed him were Professor J.

Symington, M.D., F.R.S., Professor W. H. Thompson M.D., Dr. A. R. Parsons, and Mr. T. E. Gordon F.R.C.S.

DR. ROBERT PUGH, assistant medical officer at the London County Asylum, Claybury, has been appointed medical superintendent to the Brecon and Radnor Lunatic Asylum.

### Special Correspondence.

[FROM OUR OWN CORRESPONDENT.]

#### SCOTLAND.

REPORT ON EDINBURGH DISTRICT ASYLUM AT BAYGOUR.—Dr. Frazer's report on the Asylum, which has but recently been opened, is of an entirely favourable character. Since June 1st, 182 patients have been admitted; their condition is highly satisfactory, and there has been no employment of seclusion or restraint in the treatment of any case. The employment of the patients is exceptionally well attended to, 66 per cent. being engaged in useful work, mostly on the farm, garden, or grounds, showing that full advantage is being taken of the benefits afforded by the abundance of outdoor labour possible on the Asylum estate. The day staff is in the proportion of one to nine, and the night staff of one to thirty-six patients. The permanent buildings—administrative, laundry, and superintendent's house—are well advanced in progress. The capacity of the reservoir, which is nearly completed, will be nearly 13½ million gallons, which will be adequate for all future needs. The following statement shows the number of pauper lunatics in the Edinburgh parish in 1894 and 1904:—

Year.	Royal Asylum.	Poor-house.	Other Asylums.	Private Houses.	Total
1894	346	79	6	310	741
1904	389	234	169	294	1,086

The percentage in private dwellings is 27.1, which is much higher than that in any other urban parish in Scotland.

CHALMER'S HOSPITAL, EDINBURGH.—This institution will be reopened on December 1st, after having been closed for several months while undergoing structural alterations to bring it up to the requirements of modern surgery. As stated in this column some months ago, it is an endowed non-teaching hospital partially free, partially for paying patients. The charges for the latter are very moderate, and this part of the hospital has always been fully occupied. The chief alterations made during the summer consist in the removal of the out-patient department from the main building to a structure formerly used as a laundry, which has now been reconstructed so as to include a waiting-room, consulting-room, small theatre, ophthalmic room, and surgical storeroom. The south wing of the main building, set free by the removal of the out-patient department, has been transformed into an operating theatre with adjoining sterilising and anaesthetic rooms. The theatre is floored with marble terazzo, and a special feature has been made of simplicity of fittings. The autoclave for sterilising dressings is of the latest type, supplied by the Kny Scherer Surgical Company, New York. The old operating theatre at the top of the building has been converted into general accommodation for the staff. The directors have appointed Mr. C. Balfour Paul assistant-surgeon to the Institution.

ETHER-DRINKING IN GLASGOW.—In reply to a petition of the Glasgow Corporation that ether should be included, by an Order of Council, among the scheduled poisons, the Lord President of the Council has replied that, after consulting with experts and the Pharmaceutical Society, he is of opinion that there is no adequate public reason for restricting the sale of ether in Great Britain. He points out that ether is not a poison in the ordinary sense of the word, and if it were to be scheduled because it is an intoxicant there is no logical reason why alcohol should escape similar treatment. The law at present prohibits the sale, under a



penalty of £100, of any derivative of methylated spirit as a beverage, and if any person were caught retailing ether for purposes of consumption as a beverage there would be no difficulty in proving that the ether was made from methylated spirit.

GLASGOW WESTERN INFIRMARY.—The thirteenth annual meeting of contributors was held on the 24th inst., when the report was read. 22,000 outdoor and 6,132 indoor patients were treated during the year, and 94,000 visits made. The maximum number of occupied beds was 475, the minimum 376. The average duration of treatment was 26 days, and the inclusive death-rate just under 8 per cent.

### Special Reports.

#### THE GENERAL MEDICAL COUNCIL.

THE 80th Session of the General Medical Council was opened on the 22nd inst., SIR WILLIAM TURNER, K.C.B., F.R.S., the President, in the Chair.

After the introduction by Dr. MacAlister of Mr. Arthur Thomson, M.A., Professor of Anatomy in the University of Oxford, and by Mr. Young of Professor Alfred George Barrs, M.D., as new members of the Council,

#### PRESIDENTIAL ADDRESS: THE PRESIDENT'S RESIGNATION.

The PRESIDENT, in his opening address, after referring to some recent changes in the *personnel* of the Council, passed on to the business immediately before them. He said that he had communicated to the Clerk of the Privy Council the resolution passed in May last requesting the Lord President to introduce into Parliament a Bill to confer upon the General Medical Council statutory powers to establish and maintain registers of medical and dental students, and to impose a fee not exceeding £1 for registration. Mr. Almeric FitzRoy, in a letter dated November 1st, informed him that communications on the subject had been received from the Presidents of the Royal Colleges of Physicians and Surgeons in London, and he suggested that in the circumstances it might be expedient for the Medical Council to confer with the Colleges with a view to the preparation of a scheme providing for their co-operation towards the desired end, on a basis that would, in some form or other, recognise existing rights. This matter should be considered during the present session. Copies of the judgments in the cases of "O'Duffy v. Jaffe" and "The King (Rowell) v. Registrar of Joint Stock Companies," together with the resolutions of the General Medical Council in the cases, had been forwarded to the Lord President, who had informed the Council, in reply, that his (the President's) letter was referred by him to the Board of Trade for consideration, and he communicated the opinions on the points raised which the Board had received from its legal advisers. After stating that the Council's corporate seal possessed on one side of its central figure the device of a mace, and that that emblem of ceremonial dignity and authority had up to this time been no more than a device on paper, he asked the Council's acceptance of a mace which in its design expressed their identification with the great profession of medicine and their place as the administrative body representative of the three divisions of the United Kingdom. In conclusion, he announced that, although re-elected President of the Council for a further period of five years from December 3rd, 1901, provided he remained a member of the Council, and although his appointment as representative of the University of Edinburgh did not expire until December, 1906, he had formed the opinion, after giving the subject mature consideration, that the time had come when it was advisable that he should retire from the Presidentship of the Council. His duties in Edinburgh as Principal of the University were of an onerous and absorbing nature, and had the first call on his time and energy. Through their favour and confidence, for which he could not too strongly express his grateful acknowledgment, he had occupied the chair during six years. But the business of the

Council was ever on the increase, and with advancing age he felt he should not be able to continue to discharge efficiently the duties of the responsible office to the satisfaction either of himself or his colleagues. He had to request the Council, therefore, to arrange for the appointment of his successor before the end of the present session.

The thanks of the Council were voted to the President for his address on the motion of Dr. MACALISTER, and for the magnificent present of the mace by Dr. PYE-SMITH.

#### ARMY AND NAVY EXAMINATION RETURNS.

SIR PATRICK HERON WATSON moved that the following yearly tables for 1904 be received: Table showing results of competition held on May 16th, 1904, for commissions in the medical staff of the Royal Navy; and table showing results of competition held in July, 1904, for commissions in the Army Medical Service.

Dr. McVAIL seconded the motion, which was agreed to; and the thanks of the Council were voted to the Director-General of the Medical Department of the Royal Navy and the Director-General of the Army Medical Service, respectively, for the returns which they had again furnished.

#### MEDICAL AND DENTAL COMPANIES.

The Council received and entered on the minutes a report from the Executive Committee on the dental business transacted since last session. It was stated in the report that an application from the Dental Board of Victoria for the recognition of its diploma had been received and referred to the Dental Education and Examination Committee for consideration and report during the present session. The answer of the Privy Council to the President's letter, transmitting the Council's resolution respecting companies for the practice of dentistry, and also a Parliamentary return, which had been obtained by Sir John Tuke, in regard to similar medical and dental companies, had been remitted to the Medical Companies Bill Committee for consideration and report to the Council during the present session.

#### MEDICAL "PUPILS" AS ASSISTANTS.

Mr. JACKSON asked the President whether the Council had indicated what meaning was to be attached to the phrase "the proper training and instruction of *bond-fide* medical students as pupils," occurring in the notice regarding the employment of unqualified persons as assistants or otherwise, issued on November 24th, 1897. He said it had come to his knowledge that, in certain districts—in the North of England more especially—there were cases of men who acted as qualified assistants posing as pupils; that was to say, that if any objection were taken to them the reply was that they were pupils. That had been going on for a considerable time. In one instance it appeared that a man employed in a colliery district had been an unqualified assistant under the guise of a pupil for the last thirty-five years.

The PRESIDENT, in reply, read the resolution of the Council embodying the phrase in question, and said that in a case of alleged covering it would rest with the person accused to prove that the assistant employed was, in fact, a *bond-fide* medical student undergoing training and instruction in connection with his fifth year of medical study.

The Council afterwards considered matters *in camera*, and at its rising adjourned for the day.

#### WEDNESDAY, NOVEMBER 23RD.

Much of this day's sitting was devoted to the consideration of penal and disciplinary cases.

#### THE CASE OF MR. C. J. NALLY.

The first case taken was that of Christopher Joseph Nally, registered as of 9 Hardy Terrace, Crook, county Durham, L.R.C.P. & S.I., who had been summoned to appear before the Council in consequence of his conviction at Durham Assizes on July 13th last on an indictment for unlawfully wounding his son, aged 17 months. The accused practitioner, who was sentenced to six months' imprisonment in the second

division, attended in the charge of warders. A petition largely signed by residents in the district in Dr. Nally's favour was also put in. The Council deliberated in private, and when the press were readmitted, the accused practitioner was informed that the Council had decided not to erase his name from the *Medical Register*.

#### THE CASE OF MR. H. S. REVELL.

In the second case, Hugh Stanley Revell, registered as of the Briars, West Hill Road, Southfields, London, S.W., M.R.C.S.Eng. and L.R.C.P.Lond., had been summoned to appear before the Council in consequence of his conviction at the Central Criminal Court on June 20th last on an indictment for obtaining money by false pretences from the guardians of the Wandsworth and Clapham Union. Mr. Revell, upon whom the Recorder passed a sentence which resulted in his release the same day, appeared in person and made a statement, in which he said his defence to the charges would have been that whatever had happened was through inadvertence and stress of work at a time when he was in a most anxious state of mind owing to the illness of his wife. The Council deliberated in private, and when the public were readmitted, the president informed the accused practitioner that the Registrar had been directed to erase his name from the *Medical Register*.

#### PROPOSED REGISTRATION SCHEME.

The remainder of the sitting was mainly occupied with the discussion of a letter from the Privy Council in reply to the proposal of the General Medical Council for the establishment of a register of medical students and the imposition of a registration fee not exceeding £1. Communications on the subject had been received from the Presidents of the Royal Colleges of Physicians and Surgeons, and it was suggested that, in the circumstances, it might be expedient for the Medical Council to confer with the Colleges with a view to the preparation of a scheme providing for their co-operation towards the desired end on a basis that would, in some form or other, recognise existing rights. Sir William Church stated in his letter that, from its incorporation to the present time, under the authority of its charter and statutes the Royal College of Physicians of London had determined the conditions of admission to its professional qualifications, and it claimed to have faithfully exercised the powers entrusted to it for the public good. It appeared to the College that the effect of the proposed measure, so far as it had been made known, would be to transfer to the Medical Council an important part of this power which had hitherto been safeguarded in the Medical Acts, and that it would similarly infringe the authority of the Royal College of Surgeons of England and of the Universities in granting degrees in medicine. It would, moreover, impose an additional pecuniary charge on persons entering the profession, which was believed to be undesirable and unnecessary. The President of the Royal College of Surgeons stated that the passing of such a Bill, without the introduction of restrictions, would probably enable the General Medical Council to lay down conditions of registration, and thus might transfer to that body the right, which that College had exercised for more than a century, of selecting the institutions at which the curriculum of professional study might be commenced by candidates for its diplomas. The council of the College were by no means disposed to relinquish that right. Both Colleges asked to be allowed an opportunity of expressing their views on the subject, as did also the council of the University of Oxford.

Sir CHRISTOPHER NIXON said it would be of no use having a conference with the two Royal Colleges unless they could elicit at the same time the feelings of the other Royal Colleges as to the Bill.

The same opinion was expressed by several other members, Sir ROBERT BALL and Sir JOHN MOORE stating that, in their opinion, the Bill would be opposed by the Royal Colleges in Ireland.

Sir JOHN MOORE moved, and Dr. NORMAN MOORE seconded, a resolution to the effect that a copy of the Council's resolution on the subject be sent to every

licensing body in the United Kingdom with a request that they would favour the Council with their opinion thereon.

Dr. MACKAY moved, and Sir JOHN TUKE, M.P., seconded, an amendment to the effect that, instead of going into conference with the licensing bodies, a detailed statement be prepared of the proposals of the Council with regard to the establishment of a students' register and the institution of a registration fee.

Sir VICTOR HORSLEY said that if anything were to be gained by a conference at all it must be by a farther statement on the part of the Council as to what its position was in regard to medical education, because that, apparently, was wholly misunderstood by many of the licensing bodies. The Privy Council's proposal was made in similar ignorance. The Medical Council itself was the Conference, and that fact did not seem to appeal to the Privy Council in the least, because it had all along proceeded on the lines that the licensing bodies were entitled to as much consideration as the Council. He held that that was fatal to the prospects of medical education. It was time that they made their position clear to the Privy Council.

The debate had not concluded when the Council adjourned.

#### THURSDAY, NOVEMBER 24TH, 1904.

Sir WILLIAM TURNER, president, in the Chair.

Absent, Mr. Morris, Sir Charles Ball, Mr. Tichborne.

The minutes of the last meeting were read, amended, and confirmed.

Moved by Dr. MACALISTER, seconded by Dr. LINDSAY STEVEN, and agreed to: That pursuant to a recommendation of the Executive Committee, Sir Charles Ball be added to the Medical Companies Bill Committee.

The Council then proceeded to the consideration of the case of Herbert Du Cane, registered as of 56 Bolton Road, Darwen, Lancs., Lic. Soc. Apoth. London, 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."

Mr. J. Rothwell Haslam, solicitor, attended on behalf of the Darwen Medical Society, the complainants; and also represented the husband, Mr. Taylor.

Mr. Ellis J. Griffith, instructed by Messrs. Edwards and Cohen, solicitors, attended to represent Mr. Du Cane.

After Mr. Winterbotham, the Council's solicitor, had read the notice to attend, Mr. Griffith applied for the adjournment of the hearing on the grounds that the notice was not served on Mr. Du Cane till November 7th, he being in Australia, therefore he had not had time to prepare his defence. Mr. Haslam did not oppose the application and left the matter in the Council's hands. The Council deliberated *in camera*, and on strangers being readmitted, the president announced that the application for postponement was acceded to, the case being adjourned to the May meeting, but that the documents of Mr. Du Cane's defence must be given to the Council's solicitor as soon as possible. Mr. Griffith undertook that this decision should be communicated to Mr. Du Cane.

The Council next resumed the case adjourned from May 26th, 1904, of Richard Henry Darwent, registered as of Rokeby Newington, Hull, Yorks, with the triple qualification of Scotland, 1893, who had been summoned to appear before the Council in answer to 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. Spink, a married woman whom you had been and were attending professionally, of which adultery you were found guilty by the Decree of the Probate, Divorce, and Admiralty Division (Divorce) of the High Court of Justice, made on October 29th, 1902, in the case of Spink v. Spink, Benson and Darwent, in which you were one of the co-respondents."

Mr. Darwent attended, accompanied by his solicitor.

Mr. F. W. Hill. Mr. M. P. Oldfield, solicitor, appeared on behalf of Mrs. Spink, the complainant, who was not present.

After the president had announced that the members of the Council who were not present at the previous hearing of the case should take no part in the deliberations, the proceedings at the previous consideration of the case were read.

Mr. Hill made a statement in regard to the reason why no steps had been taken to procure the prohibition of the case, for which purpose Mr. Muir (who had appeared for Mr. Darwent in May) had obtained the postponement. This was due to the expense of the proceedings. He then read a letter from Mr. Muir stating that he (Mr. Muir), being detained at the Central Criminal Court, would be unable at this time to resume the defence of his client, and asking for a postponement to a time when he would be able to attend. After Mr. Hill had asked formally for such a postponement, the Council, after having deliberated *in camera*, did not accede to this application. Mr. M. P. Oldfield, at a request from the Chair, read the confession of Mr. Darwent, which had been put in at the trial. Mr. Hill then addressed the Council on behalf of Mr. Darwent, ending with an appeal for justice to be tempered with mercy. After the Council had deliberated *in camera*, the President, on strangers being readmitted, announced the finding of the Council as follows: "Mr. Darwent, the Council has adjudged you guilty of infamous conduct in a professional respect, and has directed the Registrar to erase your name from the *Medical Register*."

At the request of Sir VICTOR HORSLEY, and with the consent of the Council, communications (remitted to the General Council by the Executive Committee) from the Medico-Political Committee of the British Medical Association respecting a letter from the Education Committee of the Borough of Bootle in regard to the giving of a medical certificate by a local chemist and druggist named Procter Williams, in the case of a girl unable to attend school, were considered while the legal advisers of the Council were present.

The Executive Committee on May 24th, 1904, resolved: That the attention of the Medico-Political Committee of the British Medical Association be called to Section 37 of the Medical Act, 1858; that they be informed that on the face of it the certificate forwarded to the Council appears to be invalid under that Section, and that the Council has no jurisdiction over chemists who give invalid certificates. A further letter, however, had been received by the Council from the Medico-Political Committee of the British Medical Association to the effect that it was well aware that the certificate was invalid under Section 37 of the Medical Act, 1858, but that the mere statement of this fact does not appear to the M.-P. Committee to constitute a sufficient recognition of the duties to the public as well as to the medical profession entrusted to the Medical Council; also that the issue of such a certificate by a person not registered as a medical practitioner is an infringement of those privileges of registered medical practitioners which Parliament by the Medical Acts created for the protection of the public, and that it is a fraud upon the public of a kind which the Council may reasonably be expected to use every effort to have punished and thereby prevent its repetition, and that the reply of the Executive Committee appears to the M.-P. Committee of the B.M.A. to indicate a failure to appreciate the true position of the question submitted for the consideration of the B.M.C.

Sir VICTOR HORSLEY said that his object was to obtain the opinion of the legal advisers of the Council as to what could be done in this matter. After some remarks by Drs. Bruce, MacAlister, Windle, Finlay, Lindsay Steven, Caton, and Pye-Smith, Sir John Moore, and Mr. Jackson, chiefly in defence of the answer sent by the Executive Committee, Mr. Muir Mackenzie expressed a desire that he might be permitted to submit his opinion in writing on the following day.

The Council resumed the consideration, adjourned from November 23rd, on the motion of Sir WILLIAM

THOMSON, of the following motion by Sir JOHN MOORE seconded by Dr. NORMAN MOORE: "That a copy of the resolution of May 30th, 1904, be sent formally to every licensing body in the United Kingdom with a request that every such body should favour this Council with their views on the subject, and that the Lord President of the Privy Council should be informed that this Council has placed itself in communication with all the licensing bodies on the subject of a proposed Medical Bill, and will in due course inform the Lord President of the result." together with the following amendment, moved by Dr. MACKAY, seconded by Sir JOHN BATTY TUKE, which, subject to the permission of the Council, has been altered to read as follows: "(1) That the Lord President of the Privy Council be informed that, in the opinion of the Medical Council, it would not be expedient at the present stage to confer with the Royal Colleges on the subject of the resolution of May 30th, 1904; (2) that before proceeding further in the matter, a memorandum be prepared, setting forth the grounds on which the Council is acting in reference to the resolution, and giving the specific proposals which the Council thinks should be embodied in the contemplated Bill." After a discussion, in which Sir Wm. Thomson, Mr. Brown, Mr. Jackson, Dr. Little, Mr. Thomson, Dr. McVail, Dr. MacAlister, Dr. Mackay, and Mr. Tomes took part, the amendment was put and carried by 17 to 5; 8 did not vote, 3 absent.

On the amendment being put as a substantive motion, the following further amendment was moved by Sir CHRISTOPHER NIXON, and seconded by Dr. BRUCE:

"That a reply be sent to the Privy Council stating that this Council now see great difficulties from opposition by certain licensing bodies in asking the Lord President to introduce a Bill giving the General Medical Council statutory power to establish and maintain registers of medical and dental students, and to impose a fee of £1 for registration therein. The General Medical Council will be prepared at the proper time to offer an alternative proposition, which it hopes may be approved by the Lord President."

A discussion followed, in which Sir VICTOR HORSLEY protested against the idea contained in Sir C. NIXON's speech of taxing medical practitioners. Dr. NORMAN MOORE went against the Council trying to extend its power. Mr. BROWN said a few words on registration of students. Sir BATTY TUKE deplored Dr. Norman Moore's remarks in decrying the influence of the Council, as it possesses the confidence of the public and of the profession. Drs. Mackay and McVail and Sir J. Moore made some remarks, and on the amendment being put it was carried 15 to 10; 4 did not vote, 4 absent. The amendment was then put as a substantive motion and carried 14 to 10; 5 did not vote, 4 absent.

Dr. LINDSAY STEVEN then moved, seconded by Dr. MCCALL ANDERSON: "That it be remitted to the Education Committee to consider and report to the next session of the Council whether the adoption by the Council of one or other or both of the following resolutions would not help to secure the attainment of the object the Council had in view in instituting the five years' curriculum, viz.: (1) That the preliminary scientific examination in physics, biology, and chemistry should be passed before the student begins the qualifying study of anatomy and physiology. (2) That before being admitted to the final examination the student should produce evidence that he has devoted the last year of his curriculum exclusively to practical and clinical work and study."

Moved by Dr. NORMAN MOORE, seconded by Dr. MCCALL ANDERSON, and agreed to: "That Clause 1 of Chapter IV. of the Standing Orders be suspended until Dr. Lindsay Steven has finished his speech in support of the motion.

The Council then adjourned.

FRIDAY, NOVEMBER 25TH, 1904.

Absent, Mr. Morris, Mr. Power, Mr. Tichborne.

After the minutes of the last meeting had been read,

the PRESIDENT informed the Council that the Registrar had that morning received a letter from the Pharmaceutical Society of Great Britain in regard to an item in the minutes of the day before. The letter was read. It was to the effect that the person, Mr. Procter Williams, who had given a medical certificate at Bootle was not on the official *Register* of chemists and druggists. The Registrar was directed to append the letter to the Minutes, which were then confirmed.

The Council proceeded to the consideration of the following memorandum prepared by Mr. Muir Mackenzie at the request of the Executive Committee in regard to the question of embodying in the Standing Orders a certain rule of procedure laid down by the Penal Cases Committee for its guidance.

#### MEMORANDUM.

As regards the form and contents of statutory declarations, the following proposed new Standing Order is framed on the basis of the rules which prevail in the Supreme Court, and is adapted from those rules so as to apply to the procedure of the Council in penal cases.

#### PROPOSED NEW STANDING ORDER AS TO STATUTORY DECLARATIONS.

After Clause 9 of Standing Order XIV. insert as a new Clause:—

"Every statutory declaration must state the description and true place of abode of the declarant, and where a fact stated in a declaration is not within the personal knowledge of the declarant the source of the information and grounds for the belief of the declarant in its truth must be accurately and fully stated.

"Declarations and parts of declarations which are made in contravention of this rule will not be accepted as evidence."

It was then moved by Mr. MACALISTER, seconded by Sir VICTOR HORSLEY, and agreed to: "That the new Standing Order be adopted."

The Council next proceeded to the consideration of the subjoined memorandum prepared by Mr. Muir Mackenzie at the request of the Executive Committee in consequence of the following resolution adopted by the General Medical Council on May 31st, 1904.

"That it be remitted to the Executive Committee to consider and draft an instruction to the Penal Cases Committee requiring them to ascertain in each case from the person or persons who have lodged a complaint against a practitioner whether the complainant or complainants have brought under the notice of the practitioner charged their disapproval of his conduct."—(*Minutes*, Vol. XLI., p. 91.)

#### MEMORANDUM.

The cases which come before the Penal Cases Committee for consideration may be shortly divided into two classes—namely, (1) those which are brought before the Committee by private individuals or societies as complainants or informants; and (2) those which are brought before the Committee by public officers or bodies, such as the medical authorities or coroners.

In the latter class of cases there is no person who can be properly called a complainant, and it would be most inexpedient, and indeed impracticable, to require a public body or official, before reporting a case of grave professional misconduct by a practitioner to the Council, to give notice to or communicate with the practitioner.

As regards the former class of cases, namely, those in which professional misconduct by a practitioner is reported to the Council or complained of by a private individual, it would, I fear, cause inconvenience and mischief, and even lead to injustice in some cases, if a general rule applicable to all cases were passed requiring the complainant, before lodging his information and complaint, to give to the practitioner notice of his disapproval of, or his complaint against, the practitioner's conduct. Such a general rule would be inconsistent with the judicial position which the Council occupies in relation to professional misconduct, and is not required for the protection of the party complained of.

If the rule were passed so that the practitioner complained of knew beforehand the subject-matter of complaint, and who the complainant was, he might attempt to arrange and compromise the matter with the complainant before the facts were placed before the Council, or might endeavour to get inconvenient evidence out of the way.

The Council's position is not that of having to decide a dispute between a complainant and respondent, but, when facts are brought to its notice, of having to decide in the interests of the public and the medical profession whether the misconduct alleged and proved against a practitioner requires the erasure of his name from the *Register*. The question whether the complainant disapproves or not of the practitioner's conduct is immaterial.

Under the present practice the complaint or information is considered by the Penal Cases Committee, and that Committee, in its discretion, decides what steps shall be taken, both as regards entertaining the complaint at all and giving notice to the practitioner.

I would suggest, therefore, that no definite instructions to the Penal Cases Committee, applicable to cases generally, should be prepared. I would submit that it may be left to the discretion of the Penal Cases Committee in any case in which in their judgment the complainant should have communicated with the practitioner before lodging the complaint, to require this course to be adopted before proceeding further with the case.

Moved by Sir WILLIAM THOMSON, seconded by Dr. MACALISTER, and agreed to: "That the Council accept the advice given in the memorandum of Mr. Muir Mackenzie and direct the Executive Committee to proceed no further in the matter."

The Council next proceeded to the consideration of the case of Robert Evans, registered as of 74 Brooksby's Walk, Homerton, London, N.E., L.R.C.P. Edin., 1885; M.R.C.S. Eng., 1885, who had been summoned to appear before the Council to answer the following charge, as formulated by the Council's solicitor: "That you have employed as assistant in connection with your professional practice a person not duly qualified or registered under the Medical Acts, namely, Griffith Ellis Williams, and have knowingly allowed such unqualified person to attend and treat patients in respect of matters requiring professional discretion and skill."

Mr. Evans attended, accompanied by Mr. Marpole, his solicitor, and by Dr. John Moore Hall, his partner, as a witness.

Mr. Wynn Westcott, the coroner, who had, as the result of an inquest held by him, brought the matter under the notice of the Council, was not present.

Mr. WINTERBOTHAM read the notice to attend, and in the absence of the complainant read the letter from the coroner to the Registrar and the depositions of various witnesses at the inquest.

Mr. Evans, examined by Mr. Marpole, denied that he had ever given orders to Williams to attend patients, and stated that he never had any suspicion that Williams was treating his patients, and that he had dismissed him at once on learning what had happened. Mr. Evans also answered questions put to him through the Chair and by members of the Council.

Dr. Hall gave evidence in favour of Mr. Evans, and Mr. Marpole then addressed the Council and read several letters from medical men (one from Professor A. Boyce Barrow), all of which spoke most favourably of Mr. Evans.

On strangers being readmitted after the Council had deliberated *in camera*, the President announced the decision of the Council as follows: "Mr. Evans, I am instructed to inform you that the facts alleged against you have not been proved to the satisfaction of the Council, and that your name will therefore remain on the *Register*."

Mr. Muir Mackenzie next read an opinion which he had prepared in answer to the question put by Sir Victor Horsley on the previous day in regard to the giving of medical certificates by unqualified persons: The first sentence of the opinion lays down: "The

effect of Section 37 of the Medical Act, 1858, is to impose a statutory duty and obligation on any public body, what by Statute is required in specified cases to be furnished with a certificate by a medical practitioner, not to accept a certificate by an unregistered person, or such a person as a chemist." However, in Mr. Muir Mackenzie's opinion, the law gives no power to the General Medical Council or to any individual to take proceedings against a public body which failed to carry this out and which accepted certificates from others than medical practitioners.

It was moved by Sir VICTOR HORSLEY, seconded by Dr. MACALISTER, and agreed to: "That this opinion of Mr. Muir Mackenzie be entered on the minutes"; and also: "That a copy of the opinion be transmitted to the B.M.A., as the answer of the Council to their letter."

The Council then proceeded to the consideration, adjourned from November 24th, 1904, of Dr. Lindsay Steven's motion, which was carried.

Moved by Mr. BROWN, seconded by Mr. JACKSON: "That the resolution of May 29th, 1893, be altered so that it reads as follows: That the fifth year be devoted to clinical work at one or more public hospitals or dispensaries, British or foreign, recognised by any of the medical authorities mentioned in Schedule A of the Medical Act, 1858, provided that in the case of students who have served one year's pupillage with a recognised practitioner holding a public appointment or possessing such opportunities of imparting practical knowledge as shall be satisfactory to the medical authorities, only six months' clinical work at a public hospital shall be exacted." Comments, mostly unfavourable, on the motion were made by Sir Victor Horsley, Dr. McVail, Sir John Moore, Sir Hugh Beevor, Sir W. Thomson, Drs. MacAlister and McCall Anderson, and the motion was lost, 24—3; 1 did not vote, 5 absent.

In answer to a question by Dr. Finlay, the PRESIDENT stated that the University of London had been visited by Sir John Batty Tuke, accompanied by the Inspector, in the present month, but that the Report would not be ready for consideration till next Session. The University of Oxford would not hold an examination till December, when it would be visited by Dr. McCall Anderson, accompanied by the Inspector. He explained that as the two Universities had been revising their regulations it was not possible to inspect the new examinations at an earlier date.

Moved by Dr. BRUCE, seconded by Mr. JACKSON, and agreed to: "That the Report by the Public Health Committee be received and entered on the minutes."

Moved by Dr. BRUCE, seconded by Mr. JACKSON, and agreed to: "That the recommendation in the second paragraph of the Report of the Public Health Committee be adopted, *viz.*, that the regulations for the Diplomas in Public Health of the University of Liverpool and of the University of Leeds be approved."

Moved by Dr. BRUCE and seconded by Mr. JACKSON: "That the recommendation contained in the last paragraph of the Report of the Public Health Committee be adopted, *viz.*, that the Council should refuse a certain application for exemption." After a discussion, in which Drs. MacAlister, Lindsay Steven, Norman Moore, Sir Chas. Ball, Dr. McVail, and Sir J. Batty Tuke took part (most of these members of the Council being against the exemption in question being granted), it was moved by Sir JOHN BATTY TUKE, seconded by Dr. McVAIL, and agreed to: "That this debate be now adjourned till Monday, November 28th, 1904."

The Council then adjourned.

#### CENTRAL MIDWIVES BOARD.

MEETING OF THE CENTRAL MIDWIVES BOARD HELD  
NOVEMBER 24TH, 1904.

DR. F. H. CHAMPNEYS in the Chair.

A LETTER was read from the hon. secretary of the Metropolitan Counties Branch of the British Medical Association, asking for the co-operation of the Board with the London County Council in obtaining powers

from Parliament to pay registered medical practitioners, when called in by midwives, in emergencies. After consideration it was decided "that the Board would give assistance in the matter, but that the suggestion must come from the British Medical Association." A letter was also read from the Clerk of the Monmouthshire County Council, asking the Board's construction of the words "otherwise than under the direction of a qualified medical practitioner." (Midwives Act, Section 1, sub-section 2.) A medical man may leave an uncertified midwife in sole charge of a case; is she then acting under his directions? After discussion Dr. CULLINGWORTH proposed that "The Central Midwives Board cannot give a general answer, the point being a legal one on which no authority has yet been given us."

Miss WILSON then moved: "That trained women inspectors be appointed by the Board to inspect institutions applying for recognition to the Board." Sir William Sinclair objected to the word "women," and it was finally decided to omit the word, and the resolution was passed.

Dr. CULLINGWORTH moved: "That the representatives of the press be required to withdraw during consideration of matters having reference to the judicial or penal powers of the Board, or of applications for recognition or approval." It was resolved "That the motion be postponed till the procedure of the General Medical Council be inquired into."

The meeting shortly afterwards adjourned.

### Correspondence.

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

TAORMI. A MINERAL SPRINGS AND SYRACUSE.  
*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*

SIR,—I have read your notes on various health resorts of Great Britain and the Continent with much interest, and having recently visited Syracuse, I shall be glad if you will allow me to state for the information of those of your readers who contemplate journeying in that direction that I found the town not only traditional as to antiquities, but amazing in its grand works of architecture, carried out by our ancestors, who were supposed to be at that epoch the conquerors of the world. We may have modified or embellished art, but we must admit, when visiting spots like this, that we are only copying on different lines what our forefathers have accomplished. Speaking from the point of view of a physician, I believe that the climate of Syracuse would suit persons suffering from hepatic disorders or chest diseases. The atmosphere is dry and bracing, rain is not infrequent, and the barometer temperate. To those who desire to visit the Taormina mineral springs in search of health and fresh surroundings, the best route is undoubtedly *via* Syracuse, and at the Grand Hotel of that city invalids and convalescents receive all care and attention; whilst visitors who are not invalids will do well to go there, not only for the accommodation afforded, but for the panoramic view obtainable therefrom, for its cleanliness and for its hygienic conditions generally, which are so unusual in these parts.

I am, Sir, yours truly,

CHARLES HELFIELD, M.A., M.B., L.M.

Malta, Nov. 23rd, 1904.

#### CONSTIPATION.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*

SIR,—Dr. Tom Robinson has hardly done himself full justice in his too brief paper he contributes to your issue of this week; but he has at least furnished a text for a discussion which might with advantage be taken up by your readers. The enormous sale of quack remedies for constipation, not to speak of aperient mineral waters, affords unmistakable evidence of the widespread prevalence of the complaint in question. It is no doubt in the vast majority of cases a merely functional derangement due to faulty personal

management and is in most cases to be cured by proper dietary, and wise personal hygiene. The suffering which accompanies the condition of sluggish bowels is very real; and in most cases patients have sufficient intelligence to trace to it the mental depression which is often its most painful symptom. No doubt it is possible to classify cases broadly, but no malady needs more careful discrimination in every instance; in none is routine treatment more certain to end as a rule in failure. On the other hand, the cases are very rare which cannot be made amenable to treatment after thorough investigation and patient experiment in dietary, habits, and administration of drugs. The habitual taking of purgatives everyone may agree with Dr. Robinson in condemning; but we must distinguish between drastic purgatives and true laxatives. Of these latter we have now a good choice; and many of them may be used habitually without ill-effect. Constipation is one of those minor ailments which the general practitioner too often neglects. In many cases he prescribes aperients without sufficient investigation, and drives the patient to seek relief from quack nostrums. With intelligent patients it will always, in the best sense of the word, pay to explain matters at full length, to assure them that permanent relief can be had if proper time and patience be bestowed on observation and experiment with both diet and drugs. This is the course which is so often overlooked by the general practitioner in dealing with other or all so-called minor ailments, and it is a course which as often loses for him the confidence of at least that class of patient—perhaps not the largest class nowadays—who have confidence in medical science and due respect for its votaries.

I am, Sir, yours truly,

G. P.

November 24th, 1904.

### Obituary.

#### DR. G. VIVIAN POORE.

DR. POORE, whose death, at the age of sixty-one, is announced, was born at Andover, and was educated at the Royal Naval School, New Cross, and at the Medical School of University College Hospital, London, taking his M.R.C.S. in 1866, and the M.D. Lond. degree in 1871, and in 1877 he was elected a Fellow of the Royal College of Physicians, London. His first professional appointment was that of surgeon on the Great Eastern steamship, while engaged in laying the Atlantic cable, and he was afterwards medical attendant to the late Duke of Albany, and in 1872 to the King (as Prince of Wales.) He also filled at various times the office of Professor of Medicine and Clinical Medicine at University College, physician to University College Hospital, consulting physician to the Royal Hospital for Children and Women, and to the Cheyne Hospital for Children at Chelsea. Dr. Poore received the decoration of Knight Commander of the Dannebrog for professional services to Princess Thyra, Duchess of Cumberland, in 1872. In 1891 he was secretary-general of the Sanitary Congress. Dr. Poore had written largely on sanitation and cognate questions, and had published a number of medical works.

#### MAJOR THOMSON, OF PENRITH, M.D., [EDIN.

DR. D. G. P. THOMSON, of Bishopsyards, Penrith, died at Algiers after a very brief illness. He was ordered to winter abroad owing to lung trouble, and only left home with Mrs. Thomson three weeks ago. Meningitis following influenza is understood to have been the cause of death. In his younger days he was an enthusiastic football player, and several times captained the Cumberland team. He was an ardent volunteer, and three years ago was promoted to the rank of Major, after commanding the two Penrith companies for several years. Dr. Thomson was also medical officer of health for Penrith, besides holding other public offices.

## Medical News.

### Irish Medical Schools and Graduates' Dinner.

THE annual dinner of this popular Association was held last week in London at the Hotel Cecil, the president, Surgeon-General C. Sibthorpe, C.B., presiding, supported by a large and distinguished company, amongst whom were many ladies. The dinner was served in the Grand Hall, and was in every way worthy the reputation of the establishment, but climatic conditions were at their worst on that particular evening, and many empty chairs were seen in consequence. Albeit everything went off with considerable *eclat*, and a thoroughly enjoyable *reunion* resulted. After the usual loyal and patriotic toasts had been duly honoured, Professor E. Halloran Bennett proposed (on behalf of Sir John W. Moore) the toast of "Our Defenders," which was responded to by Surgeon-General A. M. Branfoot and Surgeon-Lieutenant F. Swinford Edwards, the former representing the Navy and the latter the Volunteers. The toast of "Our Guests" was proposed by Surgeon-General C. B. Mosse, C. B., C.M.G., and responded to by Professor Bury and Dr. William Hill. In proposing the toast of "Ourselves," Dr. Pye-Smith, Vice-Chancellor of the University of London, said that he had the honour of proposing the toast of the medical profession of Ireland, which he regarded as the most distinguished in the world, and he regarded it as a high honour that he had been brought into contact with some of the biggest and brightest names on the Irish Medical Register. He regretted he was not an Irishman, and he could only say it was no fault of his. However, he took comfort in the fact that he had taken measures that some of his descendants would be able to compete with the native wit of the sister isle. The president replied in very felicitous terms, and proposed, as the final toast of the evening, the "Health of the Hon. Sec. Mr. Swanton," who, he said, as secretary to the committee, had worked wonders in promoting the success of the Association.

### The Hæmatogen Case.

CONSIDERABLE medical interest was aroused in this case, which was tried in June last before Mr. Justice Warrington and a jury. The action was then brought by Dr. Hommel, a Swiss physician, trading in this country as Nicolay and Co., to restrain the defendants, a Messrs. Gebruder, Bauer and Co., of Mincing Lane, London, from infringing the plaintiff's registered trade-mark, "Hæmatogen," and from passing off goods not of the plaintiff's make as and for the plaintiff's goods. The plaintiff made a preparation of hæmoglobin, which he put upon the market under the name of "Hæmatogen," and registered it as his trade-mark. The plaintiff's case was that no other preparation had been sold under the name of "Hæmatogen" in the United Kingdom up to 1902, and that anyone who asked for, or ordered, or prescribed Hæmatogen intended to refer to the plaintiff's preparation and no other. The plaintiff alleged that the defendants, who acted as the London representatives of a Hamburg firm, had recently been soliciting orders for, and selling in London, a preparation not manufactured by the plaintiff under the plaintiff's trade mark "Hæmatogen," and had been supplying his preparation in response to orders for Hæmatogen to the damage and injury of the plaintiff. The defendants, on their part, contended that Hæmatogen was not invented by the plaintiff or first used by him, but that the word was in common use in Germany and elsewhere, and that preparations so called were previously well known to medical men, chemists and scientists. The plaintiff and the defendant and a great many medical men, chemists and scientists were examined, and many dictionaries and medical text-books, both English and foreign, were put in evidence as to the origin and meaning of the word "Hæmatogen," and to show that it had not been invented by the plaintiff, but was the recognised description of an organic form of iron, or of a preparation tending to form blood.



The learned Judge held that the word "Hæmatogen" must be struck off the Register of Trade Marks on the ground that it was not an "invented word." He also held that the plaintiff had failed to show that the word had come to mean his preparation exclusively, and that the defendants had not been guilty of passing off their goods as those of the plaintiff. The action was accordingly dismissed with costs.

Lord Justice Vaughan Williams delivered judgment on Friday last, November 23rd, in the Supreme Court of Judicature; he said that he agreed with the conclusion of Mr. Justice Warrington that it had not been proved that the word "Hæmatogen" had acquired a secondary meaning as denoting only the plaintiff's preparation. His lordship did not doubt that among doctors and chemists the word had a meaning independent of its primary meaning. The Court had to consider whether among the persons who had to deal with this kind of preparation the word would mean the plaintiff's preparation exclusively, but his lordship agreed with Mr. Justice Warrington that on the evidence it was not proved that the word had acquired a secondary meaning which attached it to the plaintiff's preparation only. The appeal must therefore be dismissed with costs. Lord Justice Romer also agreed in the conclusion of Mr. Justice Warrington, and adopted his reasoning. Lord Justice Cozens-Hardy agreed, and adopted every word of Mr. Justice Warrington's judgment.

#### Charing Cross Hospital.

At the annual distribution of prizes on Wednesday last to the students attached to this hospital, the following were the chief awards for the winter session, 1903-4, and the summer session, 1904:—Epsom Scholar, Mr. N. G. Salmon; Livingstone Scholar, Mr. R. H. H. Jolly; University Scholar, Mr. W. D. Keyworth; Llewellyn Prize, certificate, and £25, Mr. J. W. Evans and Mr. R. K. Shepherd (equal); Golding Prize, certificate, and £10, Mr. R. H. H. Jolly; Pereira Prize, certificate, and £5, Mr. H. H. R. Bayley; Governors' Clinical Gold Medal, Mr. J. W. Evans; Huxley Medal, with prize of £10, Mr. W. S. Fenwick; anatomy (senior) prize, Mr. W. S. Fenwick; anatomy (junior) prize (Steadman), Mr. R. H. H. Jolly; prize (school), Mr. W. E. Wilks; biology, Mr. P. E. Stibbe; chemistry, Mr. P. E. Stibbe; physiology (senior), Mr. W. S. Fenwick; physiology (junior), Mr. R. H. H. Jolly; medicine (senior), Mr. J. W. Evans; medicine (junior), Mr. W. W. D. Chilcott; surgery (senior), Mr. R. K. Shepherd; surgery (junior), Mr. W. W. D. Chilcott; practical medicine, Mr. L. E. M. Smith; psychological medicine; Mr. J. W. Evans; ophthalmology, Mr. R. K. Shepherd; practical midwifery, Mr. E. C. Sprawson; practical chemistry, Mr. C. J. Butler; midwifery, Mr. W. K. Beaman; pathology, Mr. W. K. Beaman; public health, Mr. R. K. Shepherd; therapeutics, Mr. J. W. Heekes; forensic medicine and toxicology, Mr. W. K. Beaman; materia medica, Mr. T. W. R. Strode.

#### The Medico Legal Society.

A MEETING held on November 8th, Sir Wm. Collins, the President, being in the chair. He paid a memorial tribute to Mr. C. H. Hopwood, K.C. (a late vice-president) and hoped that the Society would see its way to appoint a standing committee to watch medico-legal progress. Dr. Clay Shaw read a paper on "An Obscure Form of Alcoholism Involving Irresponsibility," which we hope to publish in our next. Miss Louise Appel, M.B., narrated the Hindu (subjective) method of viewing responsibility. Mr. J. Troutbeck thought a physical examination of many prisoners was desirable prior to their conviction. Dr. Lewis Lewis agreed; he had known epileptics commit criminal acts after being "cured." Dr. F. S. Toogood, from his experience at Lewisham Infirmary, stated that two-thirds of the lunatics received there became sane after a few days' residence. The President thought lawyers held a statical, medical men a dynamical, view of responsibility. Delirium tremens was not, in his clinical

experience, precipitated by sudden abstention from alcohol. Dr. Stanley B. Atkinson then considered "Definitions of Accident and Accidental," as used in the coroners' court, insurance policies and Workmen's Compensation Acts. Dr. A. D. Cowburn cited cases of nervous shock and held such often led to organic derangements. Several others joined in the discussion which was concluded by the President who suggested the possible wide extensions of recent legal decisions which had confused insurance companies as to the exact nature of an accident.

#### Royal College of Surgeons of England.

THE Bradshaw Lecture will be delivered in the Theatre of the College by Professor A. W. Mayo Robson, F.R.C.S., Vice-President, on Thursday next, December 1st, at 5 o'clock p.m. precisely. The subject of the Lecture will be "Cancer and its Treatment." Fellows and Members of the College are invited to attend. Students and others who are not Fellows or Members of the college will be admitted on presentation of their private visiting card.

#### National Dental Hospital.

THE Students' Annual Dinner of the National Dental Hospital was held at the Trocadero Restaurant, London on November 19th. The chair was taken by Mr. Andrew Clark, who remarked that the President of the hospital was the Prince of Wales. In proposing the toast of "The National Dental Hospital and College," the Chairman explained how the hospital could lay claim to the title of "National," and proceeded to show that the dentist of the present time cannot be a mere mechanic, but must receive instruction in general medicine and surgery before receiving a necessary qualification to practice.—Professor A. S. Underwood, of King's College, proposed the toast of "The Past and Present Students," which was responded to by Mr. Rose and Mr. Cooke. Mr. Harry Rose submitted the toast of "The Visitors," which was acknowledged by Professor Spencer. Mr. Goadby proposed "The Health of the Chairman," and the proceedings terminated.

#### Trinity College, Dublin.

THE following have passed, during Michaelmas term, the Final Examination in Medicine—Section B: Robert A. Askins, Henry H. A. Emerson, equal; George E. Nesbitt, John W. Burns, Francis J. Usher, Charles E. C. Williams, William G. Harnett, Henry H. White, James M. Harold, John Murdoch, and Hercules J. Knox.

#### Navy Medical Service.

THE following appointments have been officially gazetted:—

*Fleet Surgeons.*—H. J. Hadden, M.B., B.A., to the "President," additional for three months' hospital course, to date November 16th; H. Elliott, M.B., to the "Empress of India"; J. M. Rogers, to the "Lion," to date November 14th.

*Staff Surgeon.*—E. A. Penfold, M.B., to the "Britannia," additional, for the "Highflyer," on commissioning, to date November 18th.

*Surgeons.*—R. Thompson, to the "Britannia," additional, for the "Highflyer," to date November 18th; M. Cameron, H. C. Whiteside, to the "President," additional, for three months' hospital course; and J. H. Lightfoot, to the "Albacore," to date November 14th.

It is announced in connection with the visit of the King and Queen of Portugal to this country, Don Antonio Maria de Lancastre, physician to their Majesties, has been appointed an Honorary Knight Commander of the Royal Victorian Order.

DR. E. BOYS RUSSELL, of Lismore, has been appointed to the Commission of the Peace for the county of Waterford.

THE first annual dinner of the United Hospitals Clinical School, University of Liverpool, will take place at the Adelphi Hotel, Liverpool, on Saturday, December 3rd, at 7.15 p.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," "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.

**QUESTIONS.**—The article on the "Sea Air Cure" contained in M.P. & C. for August 3, was virtually a synopsis of the Transactions of the Nice Congress and was derived in great measure from the excellent resume thereof published in the "Bulletin Medical d'Algerie" for 1904, fol. 327 by Dr. Bordet, of Algiers, to which we must refer you for further details.

Dr. McWALTER'S letter is unavoidably crowded out of our present issue.

### CELLULOID COMBS.

**WEST TOWN (Somerset).**—A correspondent calls attention to the danger of celluloid combs for the hair sold as tortoiseshell and encloses account of a case in which combs of the kind caught fire and inflicted serious injury to a lady's head. We thank our correspondent for calling attention to the matter, which will be found alluded to more fully in our editorial columns.

**BEEBEEBEE.**—This affection is primarily a degeneration of motor nerve-endings. The disturbing factor is apparently connected with bad food, although its precise nature has not been hitherto determined.

**A SALOP PRACTITIONER.**—The first obvious step is to make an examination of the blood. Should you not have the necessary time and skill at command send to one of the research laboratories.

### THEY LIKE THEIR MEDICINE STRONG.

Overheard in a hospital waiting room. "What was I-a-mayin' ? Oh! The medicine, its only 'art water. I looked through the pidgin-ole where they serves it out, one day, and I see the dispenser, meself, a-fillin' up the bottle out o' the water tap, and I went strite to the doctor, I did, and I see. 'Was that the way pore people orber be treated? . . . What did 'e say? . . . Only larfed, and said, 'Better complain to the Inland Revenue'; I dunno wot 'e meant." —"Our Hospitals and Charities Illustrated."

**WINSTANLEY (Beds.).**—You will find the answer to your question in the following quotation from Churchill's "Medical Directory." "In all cases where a servant falls ill or meets with an accident, and is unable to pay for necessary medical assistance, the parish is bound to supply assistance, although the servant may not have previously stood in need of parish relief. If a deputy overseer or even a mere stranger, direct a surgeon to attend a poor man, such person is liable for the surgeon's bill. A medical man called on by the police to visit a sick person in a station-house within the metropolitan district may claim the sum of 3s. 6d. for every such visit in the daytime, and the sum of 7s. 6d. for every such visit paid between the hours of 11 p.m. and 8 a.m."

## Meetings of the Societies, Lectures, &c.

### WEDNESDAY NOVEMBER 30th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. J. Smith: Clinique. (Surgical.) 5.15 p.m. Mr. G. B. M. White: Whitlow and Suppurations in the Hand.

**CENTRAL LONDON THROAT AND EAR HOSPITAL** (Gray's Inn Road, W.C.).—5 p.m. Demonstration.—Dr. Dundas Grant: Larynx.

### THURSDAY, DECEMBER 1st.

**ROYAL SOCIETY** (20 Hanover Square).—8.15 p.m. Paper: Dr. W. Cotton, of Bristol, on "The Perspective Nature of X-Ray Projection." Short note by J. H. Gardiner, Esq., F.O.S. The New Ultra-violet Glass recently produced by Messrs. Schott and Gerrosen, of Jena. Both will be illustrated by the Epiliascope.

**ROYAL COLLEGE OF SURGEONS OF ENGLAND**—5 p.m. Mr. A. W. Mayo-Robson: Cancer and its Treatment. (Bradshaw Lecture.)

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. H. Tilley: Earache, 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. Lister: Congestion of the Lungs. (Post-Graduate Course.)

### FRIDAY, DECEMBER 2nd.

**WEST KENT MEDICO-CHIRURGICAL SOCIETY** (Royal Kent Dispensary Greenwich Road, S.E.).—8.45 p.m. Mr. J. Bland-Sutton: Abdominal

Pregnancy in Women, Cats, Dogs, and Rabbits. Conventions. Exhibits:—The President: Slides in the Oxyhydrogen Lantern.—Dr. S. Barnett: Stereoscopic Skiagrapha.—Mr. J. J. Vesey: (1) Apparatus for Wireless Telegraphy (in action); (2) Some Fluorescent Materials shown in Ultra-violet Light by means of the Optical Lantern; (3) Radium and Polonium.—Medical Supply Association: Surgical Instruments.—Messrs. Duncan, Flockhart, and Co.: Therapeutic Preparations.—The Galen Manufacturing Co.: Surgical Dressings.

**WEST LONDON MEDICO-CHIRURGICAL SOCIETY** (West London Hospital, Hammersmith, W.).—8.30 p.m. Papers.—Dr. A. E. Russell: The Diagnosis of Acute Abdominal Disease.—Dr. C. R. Fennell: Juvenile General Paralysis.

**SOCIETY OF ANESTHETISTS** (20 Hanover Square, W.).—8.30 p.m. Resumed Discussion on the Vernon-Harcourt Inhaler. Dr. B. Buxton, Sir Victor Horsley, Mr. Silk, Mr. Low, Mr. MacHardie, Mr. H. Hilliard, Mr. Bakewell, and Mr. Crouch will take part.

**LARYNGOLOGICAL SOCIETY OF LONDON** (29 Hanover Square, W.).—5 p.m. Cases, Specimens, &c., will be shown by Dr. Law, Sir F. Semon, Dr. Bronner, and others.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. S. Stephenson: Clinique. (Eye.)

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital).—4.30 p.m. Lecture: Dr. Whiting: Modern Methods in the Diagnosis of Stomach Disorders.

## Vacancies.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Resident Medical Superintendent. Salary £100 per annum, with board and residence in the hospital and £5 weekly allowance. Applications to the Secretary.

Addebrooke's Hospital, Cambridge.—Secretary-Superintendent. Salary £250 per annum. Applications to the Secretary, 2 St. Andrew's Street, Cambridge.

Jersey General Dispensary and Infirmary.—Resident Medical Officer. Salary £150 per annum, with rooms, gas and attendance. Applications to Hon. Secretary, Infirmary, Jersey.

Royal Hospital for Incurables, Dublin.—Resident Medical Officer. Salary £180 per annum, with board &c. Applications to J. I. Thompson, Registrar.

Stirling District Asylum, Larbert, N.B.—Assistant Medical Officer. Salary £150, per annum, with board, &c. Applications to the Medical Superintendent.

Liverpool Dispensaries.—Assistant Surgeon. Salary £100 per annum, with board and apartments. Applications to Sam B. Leicester, Secretary, 56 Vaughan Road, Liverpool.

London Hospital, Whitechapel, E.—Medical Registrars. Salary £100 per annum. Applications to E. W. Morris, Secretary.

Holloway Sanatorium Hospital for the Insane, Virginia Water, Surrey.—Junior Assistant Medical Officer (Lady). Salary £150 per annum, with board, lodging, washing, and attendance, &c. Applications to Dr. W. D. Moore, Medical Superintendent.

Dr. Stevens' Hospital.—House Surgeon. Salary £100 per annum, with apartments, fire and light. Also a Pathologist. Applications to the Secretary. (See Advt.)

## Appointments.

JOYNS, FRANCIS JAMES, M.R.C.S., L.S.A., Medical Officer of Health for the Dursley (Gloucester) Rural District Council.

ODEN, ODENE WATSON, M.D., B.S. Durh., M.R.C.S. Eng., L.R.C.P. Lond., Honorary Physician to the Hospital for Sick Children, Newcastle-upon-Tyne.

SAUNDERS, G. J. M.B., B.S. Aberd., Certifying Surgeon under the Factory Act for the Burghhead District of the county of Elgin.

STYMS-THOMPSON, H. E. M.A., M.B. Cantab., M.R.C.P. Lond., has been appointed an Assistant Physician to the Royal Hospital for Diseases of the Chest, City Road, E.C.

SAVILL, MRS. AGNES F. M.A., M.D., M.R.C.P.I., has been appointed an Hon. Assistant Physician to St. John's Hospital for Diseases of the Skin, Leicester Square, London.

TOVEY, ARTHUR, M.R.C.S., L.R.C.P., has been appointed a Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square, London.

## Births.

MURPHY.—On Nov. 23rd, at Portobello House, Dublin, the wife of W. Murphy, L.R.C.S. and P.I., Coolgreany, co. Wexford, of a daughter.

## Marriages.

CODD—COOPER.—On Nov. 23rd, at the Parish Church, Bromley, Kent, Arthur Frederick Gamble Codd, M.B., F.R.C.S., of Holwood Lodge, Bromley, Kent, son of the late Arthur Gamble Codd, of the Inner Temple, to Ada Margaret, second daughter of Mr. and Mrs. George Quilton Cooper, of Willow Bank, Bromley.

## Deaths.

FOOTE.—On Nov. 23rd, at Portland House, Andover, George Thos Poore, M.D., F.R.C.P., youngest son of the late Commander John Poore, R.N., aged 61 years.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, DECEMBER 7, 1904.

No. 23.

## Presidential Address

ON

### THE DOSAGE OF REMEDIES. (a)

By J. THEODORE CASH, M.D., F.R.S.,

Regius Professor of Materia Medica in the University of Aberdeen

WE find chronicled an astonishing liberality in the prescription of remedies by the ancient physicians. An instructive paper published in Edinburgh by Dr. Milligan some eighty years ago gives much interesting information on this point. The wise and cautious Dioscorides ordered 62 grains of aloes as a medium purging dose, or in its place elaterium  $10\frac{1}{2}$  grains or scammony 30 grains. The antidote of Mithridatus had its 35 constituents of which opium formed the forty-third part by weight, so that calculating from the amount given, no less than 6 grains of opium would go to an anodyne dose. Marcellus ordered 31 grains of aloes as a laxative, Rufus Ephesius drachm doses of pulp of colocynth. Hippocrates ordered an obolus containing 10.5 grains of elaterium. No doubt is admissible as to the amount prescribed, as the value of the denarius, the weight quoted, is known.

Are these large doses satisfactorily accounted for on the hypothesis of Arbuthnot that the prescriptions were written in multiples (probably of 4 as suggested by Duncan) of the amounts actually intended to be administered, with the object of concealing the method of treatment, or may it have been that drugs were frequently so inert owing to imperfect methods of preparation and the presence of adulterations that such large doses were actually required to produce a desired effect? It appears to be unlikely that the ancients had any peculiar tolerance towards remedies, their physique was inferior to that of the Gauls, and though rickets, struma, and chronic rheumatism seem to have been rare among them, their excesses both in eating and drinking would predispose to disorders which would in various ways lessen their resistance.

Our knowledge of the existence, development, and separation of the active principles of plants is of comparatively recent growth, the necessity for a standardisation of many preparations has been recognised, and a further extension in this direction is desirable in the interests of exact medication.

As concerning our present system of dosage an advance has been made in the latest edition of the British Pharmacopœia by the specification for many preparations of a dosage applicable to repeated administration as well as for a single dose. The question, What is meant by repeated adminis-

tration? may not admit of an easy answer in every case. Some remedies may be repeated with advantage every two or three hours, others not oftener than every five or six hours. The speed of absorption and elimination or de-energisation must be considered carefully in this connection. On the whole the quotations of a summated dosage for a period of time such as twelve or twenty-four hours is likely to be of more use to the prescriber who desires to know what amount of his remedy may be safely but effectively given. To him should be left the distribution of the fractional doses he may elect to use, and the time of their administration.

The German Artznerbuch acknowledges this principle by quoting a "day's dose" for some of the more important drugs and preparations contained in its pages. If we examine the relationship of the day's dose to the single dose, we find that whilst in the majority of cases the summated dose is thrice the amount of the single dose, there are many exceptions to this relationship—thus, for example, whilst extract of opium has for the day's dose three times the amount of the single dose, the nitrate of strychnine has only twice as much, whilst the sodium salicylate of theobromine has six times the amount.

The dynamical properties of individual remedies, and the probable duration of their operation within the tissues, are to be considered in connection with the therapeutical purpose for which they are given. It is quite clear that a uniform system cannot be applicable to all the remedies we employ, and that the stereotyped formula "take three times a day" may often be amended with much advantage to treatment.

In order to illustrate the variation in effect producible by repeated dosage, two series of experiments were illustrated diagrammatically. The standard chosen was the fall of temperature produced by two alkaloids (A and B) nearly related to one another botanically and chemically. The plan adopted was the following:—After ascertaining the exact lethal proportion of each per kilo body weight for rabbits, a calculated fractional dose was given hypodermically at regular time intervals. The fraction of the lethal varied from  $\frac{1}{8}$  to  $\frac{1}{2}$ , and the time of re-administration from 45 minutes to 4 hours. It was found that in the case of the slightly less toxic body, the elimination or de-energisation occurred more rapidly than in the case of the slightly more toxic alkaloid.

With the former, doses of  $\frac{1}{8}$  to  $\frac{1}{4}$  of the lethal may be followed by a slight summation in effect when re-administration is made every 45' or 60', but if re-administration is at intervals of, or greater than, 90' the initial effect is neither maintained nor reproduced in extent. Even after

(a) Delivered before the Aberdeen Medical-Chirurgical Society, November, 1904.

a proportion of  $\frac{1}{4}$  lethal, there is only slight indication of summation when an interval of 90' is allowed to elapse before re-administration. Should the proportion of the dose be so large as  $\frac{1}{2}$  of the lethal, a progressive fall of temperature is observed when re-administrations occur every 45', and a fourth dose proves fatal; but if the interval is extended to 60', the same proportionate amount may be given a fourth or even a fifth time, and although a distinct summation of effect is registered, the total fall of temperature is less than that following three administrations at intervals of 45'.

These and other observations made with the body A were contrasted with those in which B was employed. As this body is eliminated or otherwise de-energised more slowly than A, greater evidence of summation is observable after doses bearing a small proportion to the lethal, re-administered at short time intervals as well as of larger proportions re-administered at longer time intervals.

It is probable that the greatest therapeutical advantage would not be derived from an identical method of employing these two bodies A and B in practice, given a permissible dose for a certain time period: the size of the fraction, as well as its allocation in point of time, would differ.

Such a conception which recognises an individuality in a remedy is no mere fancy; it is worthy of study as bearing directly upon the most efficient handling of that remedy as a therapeutical weapon.

In connection with the prescribing and preparation of remedies, an early and general adoption of the decimal system of weights and measures is highly desirable. In medicine, as in commerce, our present chaotic system is a bar to a mutual understanding with other countries, whilst it is a constant difficulty to ourselves. Our Continental neighbours, with the exception of Russia, have adopted the more workable and intelligible system, and there is no probability that they will ever relinquish it.

Our present system as applied to medicine is not merely antiquated, but intrinsically bad; as applied to commerce, its operation is well summed up by Lord Lansdowne when he describes it as "distracting to learners, obstructive to trade, and probably advantageous to no one."

There must necessarily be a period of calculation and study for those of us who are accustomed to the older system, before the gramme and the cubic centimetre become usable actualities, but the period need be but a brief one. Sir Wm. Ramsay assures us that the change to the employment of the decimal system was effected in Germany without any trouble in a week's time, and the Scandinavian countries adopted it with equal ease and celerity. I trust that our next Pharmacopœia will give doses in terms of the decimal system and thus render the transition more easy, both to practitioners and students of medicine. One other question affecting dosage is of serious importance.

When the decimal system is adopted and prescribers make daily use of it, by what method shall the patient have his dose measured? To direct that he shall take so many cubic centimetres of the contents of his bottle would probably give rise to much trouble and dangerous misunderstanding, for the system in nine cases out of ten would be foreign to him. To regulate the

dosage by the so-called "domestic measures"—spoons and wineglasses—would be a serious error, for the capacity of these individually varies enormously, so that their use is in most cases utterly fallacious. (Parenthetically, it may be stated that the capacity of the tea-spoon may be anything from 40 to 90 M, so that the patient may receive only two-thirds of his dose, or, on the other hand, half as much again according to the resources of his table equipment.)

The larger measures are even less trustworthy. Now the use of these should be altogether abandoned, and a glass measure—accurate, but of small cost—should be universally employed.

Such a measure might suitably have an eprovette from the cylinder having a height of about 20 cm., with a diameter of 2 cm. On this for graduation marks might be placed, indicating (from the lowermost upwards) capacities of 2.5, 5, 10 and 20 c.c. respectively.

The first might be indicated by the numeral I, the second II, the third IV, as it represents (2.5 c.c. x 4); the uppermost 8 (2.5 x 8). The patient might recognise these as so many parts, so that when the physician directed 4 parts at certain time intervals he would measure or have measured for him his 10 c.c., without risk of confusion.

It seems likely that some such method would materially assist the prescriber reforming his system, and if some recollection of the old nomenclature serves in any way to steady him in finding certain parallels with the newer standard, he could associate the figure 1 (2.5 c.c.) with a small teaspoonful; 4 (10 c.c.) with a large dessert-spoonful; and so on.

By the patient, who would receive an exact measure for 3d. or 4d., the outlay could only be regarded as a good and safe investment, whilst the progress of therapeutic observation would be cleared of many fallacies, which are apt to arise when an æsthetical silver teaspoon takes the place of its ample brittanic metal predecessor as the trusted domestic measure of the family.

## PAROTITIS AS A COMPLICATION OF GASTRIC ULCER.

By W. SOLTAU FENWICK, M.D., M.R.C.P.  
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AND

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INFLAMMATION of the parotid gland is occasionally observed after injuries to or operations upon the abdominal viscera, as well as during the course of certain specific fevers, dysentery, carcinoma, and phthisis. As a complication, however, of simple ulcer of the stomach the condition is comparatively rare, and scant allusion is made to it even in works which deal exclusively with diseases of the digestive organs. We find that during the five years 1898 to 1902 there were admitted into the medical wards of the London Temperance Hospital 153 cases of gastric ulcer, and that in three of these (2 per cent.) parotitis supervened while the patient remained under treatment. The actual frequency of the complication is, however, infinitely less common than these figures would suggest, since, owing to the great demands made upon the hospital accommodation by persons suffering from diseases of the stomach, cases of gastric ulcer are only admitted when suffering from hæmatemesis, perforation, or some

other important complication or sequela of the disease. The parotitis may arise either from a local infection of the gland through its duct or from general pyæmia. The former condition is by far the more common, and was responsible for the mischief in each of our three cases; but in another instance which came under our notice the formation of a small perigastric abscess due to leakage through the base of an ulcer was followed by fatal pyæmia, with secondary abscesses in the liver, lungs, and in the right parotid gland.

In each of our cases the gastric disease was chronic in character and the immediate cause of the patient's admission to the hospital was a severe attack of hæmatemesis. It is interesting to note that the parotid complication invariably ensued upon the fourth day after the hæmorrhage. In one instance the right gland alone was affected and the inflammation subsided under treatment, but in the other two the mischief became bilateral after an interval of three or four days and terminated in suppuration.

The first indication of the disease was a complaint of pain in the face or the ear, with limitation of the movements of the jaw and the development of a smooth, tender swelling in the region of the parotid. As the tumour increased in size the pain became more severe, and often radiated over the temple and the back of the head or down the neck, while in one case it was chiefly experienced in the ear and was accompanied by partial deafness. When suppuration occurred the skin over the tumour became tense and shining, and deep fluctuation could be detected on palpation. Occasionally the whole of the affected side of the face and scalp was œdematous. Unless promptly relieved by an incision, the pus showed a tendency to point behind the ramus of the jaw, to burrow into the neck, or burst into the external auditory meatus.

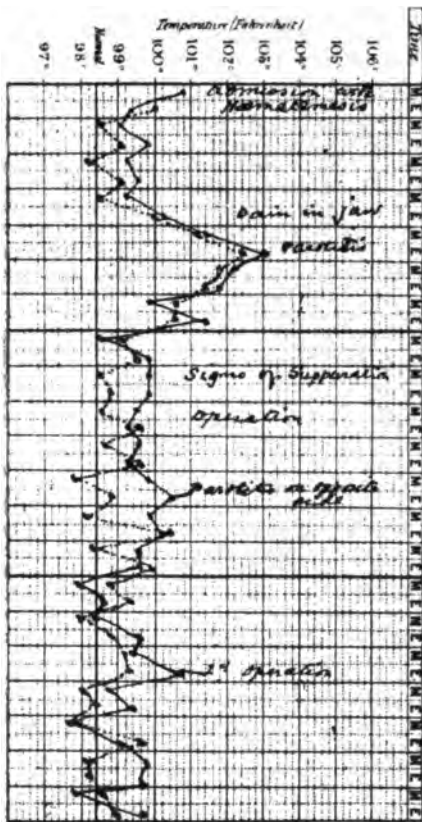
hæmorrhage and attained its maximum in twenty-four hours, after which it gradually declined until it reached its former level at the end of four days. Contrary, however, to most cases of abscess-formation, signs of suppuration did not manifest themselves until two or three days after the crisis of the fever. It is necessary, therefore, to watch the parotid swelling each day and to operate as soon as the existence of pus becomes evident, whether there be fever or no. The insidious manner in which pus may form was well illustrated in one of our cases, where, although the gland was incised and drained on the seventh day, a few days later, and without any access of fever, another abscess burst into the external auditory meatus and caused some trouble. When the other parotid is attacked a similar though less severe febrile reaction is observed.

As a rule, the state of the pulse affords a better criterion of the progress of the inflammation than the presence of fever. In each of our cases the onset of the pain and swelling was accompanied by a sudden acceleration in the pulse-rate, from about 80 to 116 beats per minute, with a further increase of rapidity when the fever subsided and suppuration occurred; indeed, it was not until the discharge had practically ceased that the pulse regained its normal rate.

During the progress of the disease, the patient complained of great prostration. The mouth and tongue were extremely foul, and the inability to open the mouth rendered it difficult to cleanse the buccal cavity. When the tension in the inflamed gland became severe partial deafness was present on the affected side, and in one case facial paralysis developed, apparently from stretching of the nerve, and did not subside until convalescence was established.

*Causation.*—Many theories have been put forward to explain the occurrence of parotitis after abdominal operations, and some authorities still seem to incline to a belief in a reflex nervous influence; but in the variety which occasionally ensues after hæmorrhage from the stomach we are convinced that the exciting cause is invariably to be found in an ascending infection of Stenson's duct. Our reasons for this are shortly as follows: (1) The parotid inflammation is invariably preceded by foulness of the mouth and never occurs if the buccal cavity is maintained in a clean and moist condition; (2) it is rarely seen in cases which are permitted throughout the whole course of the treatment to drink milk or partake of other forms of food, while it is unduly frequent in those that are nourished entirely by the rectum, all the cases that have come under our own observation having belonged to the latter category; (3) the side which is first affected seems to be determined to a great extent by the position assumed by the patient when in bed, the gland usually in contact with the pillow being that commonly attacked. Subsequently, when it becomes necessary to recline upon the opposite side owing to the painful swelling of the face, the other parotid is usually implicated. (4) A bacteriological examination of the pus obtained from the abscess always shows a mixed culture, the principal elements of which (staphylococcus pyogenes aureus and micrococcus lanceolatus) are also abundantly present in the thick secretions of the mouth.

*Treatment.*—The fact that parotitis occasionally ensues after severe hæmatemesis renders it important that special measures should be adopted to prevent its occurrence in such cases. In every instance, therefore, the state of the mouth requires immediate attention, and an effort must be made to stimulate the secretion of saliva. As a rule, constant cleansing of the mouth and tongue with a moderately strong solution of Condy's Fluid is most efficacious, but one of listerine (2 per cent.), resorcin (10 per cent.), or sulphurous acid may be employed if preferred, especial care being taken to thoroughly cleanse the spaces between the upper teeth and the cheek. In order to induce a secretion of saliva the patient should be directed to chew a piece of horseradish or pellitory root at intervals, to keep a pebbie in the mouth or to suck an indiarubber ring or teat. Sometimes the mastication of a piece of raw meat or gargling the mouth with a dilute solution of



The febrile disturbance that accompanied the parotitis was almost identical in its general features in the three cases, its course in the two instances where suppuration took place being represented in the annexed chart. It is interesting to note that the temperature began to rise on the fourth evening after the

a mineral acid is also of value as a sialagogue. If the inflammation has already set in the parts must be well fomented, and the pus should be evacuated as soon as its existence can be detected.

## A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER.

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THAT acute yellow atrophy of the liver is a comparatively rare disease in this country is sufficiently demonstrated by the fact that no case has been reported at any of the sections of the Royal Academy of Medicine in Ireland since its inception twenty-one years ago. Murchinson, in his writings about this disease, stated that during a period of nine years, and out of a total number of 27,000 patients admitted into the London hospitals, he had only seen one case, and Dr. Wickham Legg could only trace one case in the records of St. Bartholomew's Hospital for a similar period.

It is an interesting as well as an historical fact, according to Dr. William Hunter, of Charing Cross Hospital, that it was Dublin physicians who, in the beginning of the last century, first in this country made observations about the disease—Cheyne and O'Brien in the year 1818 and Marsh, four years later; Morgagni had previous to this described cases presenting features of the disease. The first accurate clinical account recorded was that by Bright in the year 1836. He described the changes which took place in the liver as "a diffuse inflammation affecting more the glandular portion than the connective tissue, leading to great diminution in the size of the organ and accompanied by intense jaundice, severe nervous symptoms and often a hæmorrhagic tendency." Two English observers—Busk, in the year 1845, and Handfield Jones two years later—accurately described the characteristic microscopic appearance of the degenerated liver cells, and about the same time Continental investigators confirmed these observations and added more to what had already been made known.

The patient, E. B., was admitted into Jervis Street Hospital on August 24th last. She was a well-nourished woman of medium height and build, with dark hair and dark complexion, æt. 27. She was born in Dublin and had a good personal and family history. She had been married five years, had three children, the youngest of which was four weeks old; the other two, aged respectively 4 and 2 years, were strong and healthy. She had not had any miscarriage, nor was there a history of a rash or sore throat, so that syphilis as a cause must be excluded. Her husband, a labourer by occupation, was not always steady or at regular work, which necessitated her doing washing, and in this way she contributed to the support of her family. She had not been in the habit of taking either porter or any other stimulant. She resided in a tenement house situated in one of the most congested parts of the city, where the surroundings could not be anything other than detrimental to a robust state of health. While carrying her last baby she enjoyed average health, as she did on the two former pregnancies. Parturition seemed to have been normal and she was able to be up and about at the end of one week, and, as with the other two children, she nursed this child. In the beginning of the third week after her confinement, she felt sickness of stomach, loss of appetite, languor and the jaundice first appeared three weeks after child-birth. A week later, she first came under my care. At that time there was nothing in her condition to suspect anything other than an ordinary case of catarrhal jaundice. The liver dulness was not affected, no hardness or resistance of the organ could be detected and the gall-bladder was not distended; there was no pain on pressure. The tongue was thickly coated, enlarged, flabby, and indented with teeth marks—the teeth were exceptionally good; the tonsils were normal and no enlarged glands could be found. The abdomen was soft and flaccid, no rigidity

at or about the liver region, all the abdominal organs seemed normal, as also the heart and lungs. There was marked constipation and more sickness of stomach perhaps, than one usually gets in a simple case. The skin and mucous membrane presented all the appearance of a well-marked case of jaundice, as also did the urine. The quantity of urine passed per day was below the average, 35 oz. Urates were abundant there was a slight trace of albumin, no sugar, sp. gr. 1022, and the quantity of urea was less than normal. At this time leucin and tyrosin were not looked for. There was one other symptom patient complained of on admission—*viz.*, a shooting, acute, spasmodic pain lasting only a short time, apparently in the liver. She stated that the pain was deep-seated and scarcely ever occurred in the exact place a second time, and her description of the pain was as it were the stab of a sharp instrument. External pressure had no effect in either relieving or increasing it, nor did a deep breath affect it. All through her illness this symptom was prominent and towards the end became sometimes so severe that she had to cry out. Her temperature was normal and pulse 62 per minute. Stools typically those of jaundice.

For the first week in hospital this patient seemed to improve, took light nourishment well; the tongue became cleaner and the jaundice was apparently not so intense. The bowels, however, required strong purgatives. There was no trouble with the breasts, as the milk ceased coming at once, although she had been suckling her child until her admission. During her second week in hospital the patient did not feel so well, the nausea and epigastric discomfort became very marked, the bowels more stubborn and the jaundice more intense. From this until her death the patient got gradually worse, vomiting became almost incessant, the liver dulness diminished in area, and it was now found the amount of urea was diminished to about half what it was on admission and leucin and tyrosin were present. The temperature now became irregular, varying from 96.5 to 102°, and the pulse intermittent and fluctuated between 80 and 120. There was no direct relationship between the temperature and pulse; when the temperature was high, the pulse might be low and *vice versa*.

At the end of the third week in hospital cerebral symptoms developed; she gradually became drowsy and semi-conscious, was restless and had slight delirium—the jaundice became very intense and appeared as a greenish hue; the tongue became dry and brown, and the amount of urine passed diminished to 13 oz. per day. The liver dulness practically disappeared in front and only posteriorly could it be slightly detected. She remained in this condition for three days, but gradually becoming more unconscious and weaker, and died about four and a half weeks after the jaundice first appeared. The vomiting was always gastric; at no time had she any hæmatemesis, mælena, or any other hæmorrhagic manifestations.

In the *post-mortem* room the body was not much wasted considering the severity of her illness and the small quantity of nourishment she was able to make use of. On opening the abdomen there was found a small quantity of greenish-coloured fluid. The liver, instead of presenting as usual, was small, baggy-like and collapsed, and could only be seen by its being kept in position by the suspensory ligament. When removed it felt soft and spongy-like, with a wrinkled capsule and weighed 29 oz. The stomach was small, and on opening it the mucous membrane was found to be pale and apparently healthy. The other abdominal organs seemed to the naked eye normal. The spleen, pancreas, and the kidneys seemed healthy in size and on section. The uterus was normal and there was a small ovarian cyst about the size of a marble. None of the abdominal glands were enlarged. The heart and lungs were healthy and there was not any fluid in the pleural cavity or pericardium. I did not get an opportunity of examining the brain.

The clinical points of interest about this case are:—

1. The rather protracted course—about four and a half weeks, although Hunter in his twenty-nine



collected cases gives nine, or 31 per cent., as running a course of from three to eight weeks.

2. The acute, short, spasmodic liver pain which was persistent throughout.
3. The total absence of any hæmorrhagic symptoms.

ABSTRACT OF THE  
**Bradshaw Lecture**  
ON THE

**TREATMENT OF CANCER. (a)**

By A. W. MAYO ROBSON, F.R.C.S., Hon.D.Sc.,  
Vice-President of the College.

PREVENTIVE OPERATIONS.

*Precancerous Conditions.*—The so-called precancerous stage of malignant disease may be due to disturbances of nutrition, to previous injury, to congenital defect, or to other departures from the normal conditions.

Senility and decadence of tissues which have passed the period of their usefulness and are about to undergo physiological rest are predisposing factors. Predisposing conditions also exist in certain parts of the body where embryological vestiges or rests are found, and in certain regions, as the pylorus and the cæcum, and at the lines of junction of skin and mucous membrane.

In certain situations precancerous conditions can be readily recognised, especially in the tongue, lips, larynx, uterus, and the skin, suggesting strongly that cancer is a new implantation on a prepared ground. Probably, if we could only find it, every cancer, whether external or internal, follows on a precancerous condition. The liability of benign tumours, especially on epithelial surfaces, to undergo malignant changes is well recognised, hence the removal of such is generally advisable.

A general acceptance of the view that cancer has usually a precancerous stage, and that this stage is one in which operation ought to be performed, would be the means of saving many useful lives, for it would lead to the removal of all suspicious epithelial conditions before the onset of cancer. I hold that the arrest or removal of known causes as well as the abolition of discoverable precancerous conditions, whenever or however occurring, constitute true preventive treatment.

*The Gall-Bladder and Liver.*—The lecturer said that facts recorded by himself and by Zenker, Courvoisier, Schroeder, Beadles, and Rolleston established an undoubted relationship between cholelithiasis and cancer of the gall-bladder and ducts.

As gall-stones produce characteristic symptoms, and are therefore as a rule diagnosed early, and as they can be removed before serious complications have supervened with extremely little risk (in my experience, extending over some hundreds of operations, less than 1 per cent.), the preventive treatment for cancer of the gall-bladder is obviously removal of the source of irritation.

So impressed am I with the importance of this view, that although I know the symptoms of gall-stones, which frequently depend on the associated catarrh, can often be relieved for a time by general treatment (though the gall-stones producing the catarrh cannot be removed by medicine), yet I consider it wise to recommend their early removal, not only because it can safely be done, but also because the symptoms are likely to recur and lead to other complications, and not least important because in a considerable percentage of such cases malignant disease will supervene if the irritation be not removed.

*The Mammary Glands.*—In the breast there are certain well-known precancerous conditions, such as eczema of the nipple (first described by Sir James Paget as a precursor of duct cancer), chronic inflammatory enlargements (the chronic cirrhosing mastitis of Billroth, the interstitial mastitis of English pathologists), cysts and adenomata, and last, but not least, induration following on injury. Many of these conditions will, if

(a) Delivered before the Royal College of Surgeons of England on December 1st, 1904.

properly and seriously attended to, yield to treatment. Patients have usually themselves to blame for ignoring what they seem to think are trifling ailments, though sometimes the medical attendant may, to avoid frightening his client, make light of the condition. I would say far better to alarm and cure than to lull into a false sense of security, and have to counsel operation later when the conditions are less favourable for radical treatment.

If eczema of the nipple does not speedily yield to treatment, the nipple should be freely excised, and with it the first portion of the primary ducts. If a chronic inflammatory swelling does not disappear under adequate treatment, the lobule or lobules involved ought to be removed, or, if general, the breast should be ablated. Cysts or tumours, even if simple, should be taken away, and if, on examination after removal, there is any suspicion that the simple stage is passed, the whole breast should be removed, and with it the nearest lymph glands.

It ought to be recognised that the watching of a doubtful tumour of the mammary gland until it becomes definitely malignant is an unjustifiable and a blameworthy procedure. Removal in this stage can be done without risk, and while the anxiety of the patient is relieved the fear of the development of malignancy is removed.

*The Stomach.*—Precancerous conditions of the stomach are, in certain cases, distinctly recognisable, and, if diagnosed and treated, might save many patients from carcinoma. As the stomach is one of the commonest sites of cancer, if even a percentage of cases can be saved from malignant disease by timely treatment a great advantage will have been gained.

Carcinoma occurs most frequently in those areas in which the ulcers chiefly lie. Whatever the frequency of the malignant change in chronic ulcer may prove to be, the fact of its occurrence should be an additional incentive to the earlier surgical treatment of ulcers which prove rebellious.

I firmly believe that greater regard for oral asepsis and more careful attention to the teeth would save much stomach disease, and I think one of the chief causes of the frequency of gastric ulcers among the mill operatives of Yorkshire and Lancashire is carious teeth with its accompaniment, oral sepsis. I am also firmly convinced that the early and thorough medical treatment of gastric ulcers and the surgical treatment, either by gastro-enterostomy or excision of those that prove rebellious, would do much to lessen the amount of cancer of the stomach.

*The Pelvic Organs of Women.*—Cancer is perhaps more commonly noticed to supervene on a recognisable precancerous condition in the uterus than is observable in any other organ, and the frequency with which cancer develops in multiparæ, and especially in those who have had lacerated cervix, points distinctly to cause and effect.

The frequent advent of cancer on old scars is well known in various parts of the body, especially in those placed where their nutrition is liable to disturbance, as in the scars of burns. Now in the cervix uteri we see the scars of old ulcers, the result of laceration in childbed, often remaining untreated for years and leading to constant distress, with backache, leucorrhœa, and other well-known symptoms. Only a few months ago, I saw a case of this kind pass from the simple to the malignant stage, an operation having been declined on both occasions when I saw the patient, and only consented to six months later, after epithelioma had developed. Cancer of the cervix uteri is infrequent in sterile women whose cervical canal has not been subjected to the lacerations which often occur in parturition, whereas cancer of the body of the uterus is of equal frequency in those who have and have not borne children. Most careful attention to post-puerperal conditions and the performance of the simple operation described by Emmett would remove this source of danger in a great number of cases.

Uterine adenomata doubtless predispose to cancer

of the uterus, and the co-existence of mucous polyp and epithelioma is not without its significance, as early operation in such cases would probably prevent the onset of malignant disease. The malignant degeneration of uterine myomata is probably commoner than is generally supposed, and on several occasions I have removed what was supposed to be a simple myoma of the uterus, and found a sarcomatous change going on. As myoma of the uterus can be removed by hysterectomy with very small risk, I make it a rule, whenever a myoma begins to enlarge at or near or after the menopause, to advise its removal; while I hold with those writers who recommend the removal of "fibroids" whenever the symptoms of hæmorrhage, pressure, or pain seriously interfere with health or comfort. Surely, it is better to accept a risk of 2 to 3 per cent., with a view to the removal of a disease that in itself promises to endanger life, and which in a certain percentage of cases undergoes a malignant change, than to have to operate when cancer or sarcoma have already developed, and when the risk of operation will be seriously increased and the chances of permanent cure very much lessened.

The fact that malignant disease of the ovary begins in the first place as a small tumour (often cystic), and that cystic disease is apt to undergo malignant degeneration, affords good ground for recommending operation at an early stage in the case of any ovarian tumour, when perchance the disease may be caught in a precancerous condition; or should malignant disease have already commenced it will be limited and removable.

*The Intestines.*—Though, on account of its inaccessibility to direct examination, a precancerous condition is difficult to diagnose in the upper intestines generally, it will be found in many cases that there have been premonitory symptoms pointing to ulcer or colitis. Irregular pains, the passage of mucus or blood, and constipation, possibly alternating with diarrhoea, should rouse a suspicion of organic disease, and lead to a careful physical investigation that may reveal irregular peristalsis or possibly a tumour, which, even if not caught in the precancerous stage, will be recognised, and treated in the incipient and curable stage of cancer.

Any disease high up in the rectum or in the lower loop of the sigmoid flexure is quite out of reach of the finger, and cannot be palpated through the abdominal wall unless of considerable size; here, as a rule, disease has had to be diagnosed by symptoms alone, and symptoms sufficiently definite to warrant exploration only come on when the disease has passed the most favourable time for radical treatment. Fortunately, by means of the electric sigmoidoscope invented by Professor Strauss, of Berlin, to which attention was drawn by Mr. P. L. Mummery, a clear view of every portion of the inside of the bowel may be obtained, even as high as the top of the sigmoid flexure, without inconvenience or danger to the patient. It will do away with the need for exploratory operations in this region for mere diagnostic purposes, and will enable disease to be more frequently removed in the precancerous condition.

In the rectum the earlier treatment of hæmorrhoids and ulcers and of all chronic sources of irritation is obviously rational and advisable, and may sometimes be the means of preventing the onset of malignant disease.

#### RADICAL TREATMENT OF CANCER.

By the radical treatment of cancer I mean the entire removal of the disease at an early period, together with a wide margin of healthy tissue, and, if practicable, the nearest lymphatic glands.

In estimating what may be done for cancer by radical treatment, I do not think it sufficient simply to consider the mortality of any special operation, as has so often been done, when operative success was used as a cloak to mask therapeutic failure, but I want to know the ultimate results, after the lapse of years, of operations undertaken at an early stage of the disease, where the cancer had been freely and widely excised. Nor do I think it fair to surgery to average the statistics of all surgeons, or even of all hospitals, but rather to select the statistics of operators interested in special lines of work who can show what can be done in their

own particular region. The levelling process should, from my point of view, be a levelling-up to the best and not an averaging down to the worst.

*Cancer of the Breast.*—In my experience in hospital and in private practice I can point to a very large number of radical mammary operations, and I have been astonished to find how many, especially of the private cases where, through the kindness of the family physicians, I have been able to trace the after-histories, have survived beyond the three years' limit, and how many are still living and well many years after operation.

Of the 62 operations I have done in private practice for cancer of the breast, there was no operative mortality, 23 survived the three years' limit, and 20 are now alive and well at periods up to twelve years after operation; 5 died from other diseases without recurrence of cancer, 1 twenty years after the major operation, 28 had recurrence, though in 8 it was over three years subsequent to operation; 8 could not be traced.

My early operations were not so thorough as those done in later years, otherwise I feel sure that the recurrences would have been even fewer.

To Dr. Halstead, of Baltimore, belongs the distinction of carrying operations for cancer of the breast to their widest limits at the Johns Hopkins Clinic, of which the following is a brief account of the ultimate result of 161 patients admitted with operable primary tumours of the breast, on whom complete operations were performed between June, 1889, and August, 1890.

In August, 1902, 60 patients were living and cured 7 had lived over three years and died from other causes, and 2 had died from other causes with the three year limit, autopsy showing no signs of recurrence. This gives 60 cases, or 42·8 per cent., positively cured. An analysis of the 161 patients shows that 83, or 51·5 per cent., survived the three year limit.

The operations performed consisted of complete excision of the breast, both pectoral muscles and axillary contents in one piece, and complete excision of the contents of the supraclavicular fossa. During thirteen years 305 patients with primary and 38 with secondary tumours were admitted to the clinic, and of these it is worth noting that 83, or 27·2 per cent., were inoperable, owing to delay in seeking surgical assistance. It is also of interest to note that in no case was local recurrence or internal metastasis observed after three years.

Mr. Bryant has recorded from his own experience 46 cases of amputation of the breast for cancer, in which the patients survived the primary operation from five to thirty-two years.

My colleague, Mr. Watson Cheyne, adopting a most thorough and radical operation on lines similar to those of Professor Halsted, shows very satisfactory results. He says that, taking the average of all cases operated on, favourable or otherwise, something like 50 per cent. will remain well for a number of years, and in these cases, in which the tumour is small and well limited, and the glandular infection is slight, the proportion of successes will be considerably greater. In these views I most thoroughly agree.

Cancer of the breast, if operated on early and with thoroughness, is by no means the incurable disease that many still think; in a very large percentage, 50 or more, the patients may look for over three years' respite; and in 40 per cent. to a much longer period of freedom, and many to a genuine cure.

#### RADICAL TREATMENT OF CANCER OF THE STOMACH.

It was only in 1879 that Péan performed his first pylorotomy for cancer of the stomach, and in 1881 that Billroth did the first successful operation; before that time, and long after by many, the disease was held to be incurable. At first sight it would appear to be hopeless to expect that eradication of the disease could be possible in an organ situated as the stomach is and so freely supplied with blood vessels and lymphatics; yet a careful study of its anatomy shows it to be fixed only at the cardiac extremity, and with the exception of that part the remainder is as freely accessible for

operative purposes as the intestines; moreover, the disease if caught early can be completely removed. I can point to a number of patients in good health on whom I performed partial removal of the stomach years ago, and to one especially.

A man, *æt.* 42, from whom I removed the whole stomach, except a small portion of the dome and the cardiac orifice, four years ago. He was reported last month to be robust and well, to be able to take quite ordinary diet, and to have followed his business without any disability from within two months of his operation up to the present time.

In another case, a woman, *æt.* 54, a partial-gastrectomy was performed at the same time as removal of the gall-bladder, both organs being involved in cancer. She remains well now in the fifth year after operation. In another case, a woman of 50 remains well nearly four years after the removal of the centre of a cancerous hour-glass stomach, the proximal and distal healthy portions having been joined over a decalcified bone bobbin.

Whenever a patient at or after middle age complains somewhat suddenly of indefinite gastric uneasiness, pain, and vomiting, followed by progressive loss of weight and energy, and associated with anæmia, the possibility of cancer of the stomach should be recognised, and if no improvement takes place in a few weeks at most, an exploratory operation is more than justified. Our diagnosis can only be rendered certain by a digital examination, which may be effected through a small incision that can, if needful, be made under cocaine anæsthesia with little, if any, risk.

Removal at any early stage offers good prospects of immediate recovery and a fair probability of cure, and excision of even a considerable portion of the stomach may be something more than a palliative operation. Although it is better to have cancer diagnosed and operated on early, yet we need not take the pessimistic view that if a tumour be manifest it is too late to perform a radical operation.

#### CANCER OF THE TONGUE.

I remember as a student seeing a number of removals of the tongue by the *écraseur*, there being no question of removal of the glands or of the floor of the mouth. In nearly every case recurrence took place within a few months, and the operation was falling into disfavour, when Whitehead invented his operation of removing the tongue widely with scissors, and Kocher's operation of clearing out the tongue, floor of the mouth, and the submaxillary and lymphatic glands also came to be practised.

These operations brought a marked change, and it was soon found that a good percentage of patients operated on remained free from disease for some time, and others were really cured. I can point to a case, well, seven years after operation, to another five years, and to others over three years, and it is of interest to note that in these cases very good power of speech is retained by the patients.

If only diseases of the tongue were attacked in the precancerous stage: if only this were done more frequently, and if, even when cancer had developed, time were not lost in dosing patients with iodides week after week until the disease has extended too widely, there would be a much brighter tale to tell.

#### CANCER OF THE LARYNX.

What could at first sight appear more hopeless for radical treatment than cancer of the larynx, which formerly used only to be treated palliatively by tracheotomy, later was removed by the formidable operation of complete laryngectomy with a very high mortality, and, lastly, has been most successfully dealt with, when seen early, by the much more simple operation of thyrotomy and removal of the diseased part, as advocated by Mr. H. T. Butlin in 1889? My friend, Sir Felix Semon, has been kind enough to give me the statistics of his thyrotomy operations, the results of which are remarkable, and which prove up to the hilt the special point which I want to insist on in this lecture, that if we get cancer cases sent to us sufficiently early, operation is not merely palliative, but curative.

#### RADICAL OPERATIONS FOR CANCER OF THE INTESTINE.

Intestinal cancer is nearly always columnar-celled carcinoma, and even when it has advanced to a fatal issue, the disease is limited to the gut in over 40 per cent. of cases. I believe that all the cases in which the disease is limited ought to be capable of cure by enterectomy if operated on early. It should also be borne in mind that even if enlarged glands be present it does not necessarily mean that they are cancerous, for clinical and pathological experience has shown the contrary. In some of my own cases, enterectomy, despite the presence of enlarged glands, has resulted in cure.

In all chronic ailments associated with dyspepsia or constipation or abdominal pain, a careful examination of the abdomen should be made in order to discover disease at the earliest possible moment, for to wait until obstruction occurs is to lose the favourable moment, and to add very seriously to the danger of any operation.

In operating I make a very wide sweep of the disease, going several inches beyond the growth above and below, and removing the lymphatics and glands belonging to the affected parts of the bowel as far as possible. Personally, I prefer to use my decalcified bone bobbin, but I have employed with success the simple suture and the Murphy button, though I still feel that by means of the bobbin used as a temporary splint around which to apply sutures, I can perform a safer operation than by any other method.

#### CANCER OF THE RECTUM.

This is an affection that of all others lends itself to a radical cure, for it can be recognised early. It is safe to say now that there is no part of the alimentary canal that cannot be reached for a radical operation, for even in the rectum that part which cannot be reached from the perinæum can be got at from above by opening the abdomen with the patient in the Trendelenberg position, as was so ably demonstrated by my friend, Sir Charles Ball, from this chair last year; and, fortunately, there need be no doubt about the nature and extent of the disease in this region, for the electric proctoscope enables the lower bowel to be examined by the eye without difficulty to a height of 30 centimetres.

Among other notable examples of radical cure, I can point to one patient living in perfect health and with good control of the bowel, from whom I removed a cancer of the rectum by proctectomy twelve years ago; to another, eight years; and to others who are well and enjoying life several years after operation.

#### CANCER OF THE GALL-BLADDER AND LIVER.

If the favourable precancerous period has passed, and malignant disease has actually supervened, can anything be done for the sufferers?

At first sight it would appear that cancer of the gall-bladder is an utterly hopeless disease, especially when it has extended to the liver. I have, however, operated on 12 cases of cancer of the gall-bladder, and in 11 the disease extended to the liver, forming the tumour of some size. Of these 12 cases 10 recovered from the operation and lived for varying periods. Five of these patients are at the present time alive and in good health at periods of 5½, 5, 4½, 4, and 1½ years respectively subsequent to operation. These were cases of primary cancer of the gall-bladder due to the irritation of gall-stones, and the liver growth was due to extension by continuity, not to secondary deposits in that organ. In one case I was able to remove as much as half a pound of the liver with success.

*Cancer of the Lip.*—Even if the precancerous stage has passed, a free removal of the disease at an early stage and while it is still local enables a very good prognosis to be given.

*Cancer of the Penis.*—In epithelioma of the penis amputation yields a cure in one-third of the cases operated on.

*Cancer of the Uterus.*—Much may be done to prevent this dread disease by careful surgical treatment, and that without risk. Even when the precancerous stage is passed, if women could be educated to the fact that were they to seek advice earlier, and, in fact, whenever

an abnormal sanguineous discharge appears, apart from a menstrual period, in a very large percentage of cases the cancer would be recognised in its incipient condition when the disease is local, and removal could be carried out and cure effected.

It seems to be most desirable that some crusade against the neglect of the well-known early symptoms of uterine cancer should be undertaken, and that women should be warned how important it is for them to consult their medical attendants at an early stage, when, in case of doubt, a small piece of tissue can easily be removed and examined microscopically.

In conclusion, Mr. Robson remarked that his purpose would have been served if he had been able, in however small a degree, to convince those who had the chance of seeing patients in the early stages of their illness, that in many cases cancer could be prevented by treatment in the precancerous stage; that even when cancer had developed, if it were seen early and thoroughly removed, it was frequently a curable disease; and, lastly, that even in the later stages much might be done by surgical treatment to give real relief.

Was it too much to hope, he asked, that some of the views he had enunciated might filter through the profession to the public, and serve to convince them that until a true prophylactic for cancer was discovered, they would be consulting their own interests best by seeking medical advice earlier, since to trifle with their ailments in the early stages was to lose the favourable moment and ultimately to hear the verdict—alas, too often pronounced—too late!

#### Royal Free Hospital.

The following scholarships have been awarded at the London (Royal Free Hospital) School of Medicine for Women: St. Dunstan's Medical Exhibition of £60 for five years to M. Muncey, the School Scholarship of £30 to E. M. Morris, two Mackey prizes of £20 each to E. Griffiths and E. H. Lepper, the Fanny Butler Scholarship of £14 10s. to G. M. Stagg.

#### Mater Misericordiarum Hospital, Dublin.

At a meeting last week of the Medical Board of the Mater Misericordiarum Hospital, the following appointments were made:—Temporary Assistant Surgeon, Mr. Denis Keane, M.B., B.Ch., B.A.O.R.U.I.; House Physicians, Drs. Thomas Barry, M.B., B.Ch., B.A.O.R.U.I., and William L. Murphy, B.A.Cantab., L.R.C.P.I., L.R.C.S.I.; House Surgeons, Messrs. Thomas Cronin, M.B., B.Ch., B.A.O.R.U.I., Richard Flood, M.B., B.Ch., B.A.O.R.U.I., and Michael Keane, L.R.C.P.I., L.R.C.S.I.

#### St. Thomas's Hospital.

THE following have been selected as House Officers from yesterday (Tuesday):—Resident House Physicians:—B. Higham, M.R.C.S., L.R.C.P. (*Extension*); W. Haward, M.B., B.S.Durh., M.R.C.S., L.R.C.P. (*Extension*); A. G. Gibson, B.A., M.B., B.Ch.Oxon., B.Sc.Lond.; K. Takaki, M.R.C.S., L.R.C.P. House Physicians to Out-patients:—R. E. Whitting, M.A., M.B., B.C.Cantab.; F. A. Brodribb, M.R.C.S., L.R.C.P. Resident House Surgeons:—H. S. Bennett, M.R.C.S., L.R.C.P.; N. C. Carver, B.A., B.C.Cantab., M.R.C.S., L.R.C.P.; A. C. Birt, M.R.C.S., L.R.C.P.; G. T. Birks, M.A., M.B., B.C.Cantab. House Surgeons to Out-patients:—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. De Vaughan, M.R.C.S., L.R.C.P. (*Extension*), Obst. House Phys.:—(*Senior*) H. I. Pinches, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; (*Junior*) E. W. Parry, M.R.C.S., L.R.C.P. Ophthalmic House Surgeons:—(*Senior*) H. S. Stannus, M.B.Lond., M.R.C.S., L.R.C.P.; (*Junior*) A. B. Bradford, M.B., B.S.Durh., M.R.C.S., L.R.C.P. Throat Department:—C. N. Sears, M.B., B.S.Lond., M.R.C.S., L.R.C.P.; D. K. Coutts, M.R.C.S., L.R.C.P. Skin Department:—W. L. Harnett, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. (*Extension*); F. M. Bulley, B.A.Cantab., M.R.C.S., L.R.C.P. (*Extension*); Ear Department:—T. Guthrie, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. (*Extension*); L. E. C. Norbury, M.R.C.S., L.R.C.P.

## Clinical Records.

### ROTUNDA HOSPITAL, DUBLIN.

#### A Case of Caesarean Section.

Performed by E. HASTINGS TWEEDY, M.D., &c.,  
Master of the Rotunda Hospital.

[Recorded by A. N. Holmes, M.B., B.Ch., B.A.O.U. nrv. Dub., and L.M., Assistant Master, Rotunda Hospital.]

IN view of the fact that Caesarean section is so great a rarity in this country, it may prove of interest to cite the following case, which occurred recently in the Rotunda Hospital.

A. O'R., primipara, æt. 29, was admitted to the hospital on Sunday evening, November 6th, at 8 p.m. She was a very small woman, her height being 4 ft. 3 in. and her limbs and pelvis presented well-marked rachitic deformity.

On inquiry she stated that, as far as she knew, she was up to full term, and, further, that the membrane had ruptured several hours before she came into hospital. She was not having any pains.

On inspection, there was seen a prominent tumour over the symphysis pubis, which palpation proved to be the head, freely movable. Fœtal movements were also felt and the heart heard. A vaginal examination was made and the promontory felt with the greatest ease low down, and the os, which was high up, admitted one finger. Pelvimetry was at once done, and the following measurements obtained:—Conjugata vera, 6 cms.; transverse, 11 cms.; interspinous, 25 cms.; intercrystal, 24.8 cms.; extern. conjugata, 17 cms.

On finding these, Caesarean section presented itself as the only means of delivery. As the patient showed no signs of labour, the following morning at 10.30 a.m. was fixed on for operation should no indications for earlier interference arise.

In the morning the patient had one or two slight pains about 9.30 a.m. At 10.30 a.m., the master, Dr. Hastings Tweedy, assisted by Sr Arthur Macan and the two assistant masters, opened the abdomen by a six-inch incision, having the umbilicus as centre. An assistant kept the incised wound in close apposition to the uterus to guard against the possibility of fluid entering the abdominal cavity. The uterus was now rapidly laid open by a five-inch incision along the interior aspect of the upper uterine segment. In doing this the placenta was encountered and occasioned smart hæmorrhage. Without making any effort to control this, a limb was seized by the hand and the fœtus having been rapidly removed, was handed over to the care of an assistant. The uterus with its contained after-birth, was now delivered from the abdominal cavity, and all the hæmorrhage from it controlled by the hand of an assistant tightly compressing the cervical region. Another assistant temporarily closed the upper part of the abdominal incision by means of a bullet forceps, whilst a moist sterilised towel protected the uterus from the skin. During the progress of these procedures, the master was engaged in detaching the after-birth, and it was curious to note the rapid and marked thickening of the muscle which took place despite the absence of uterine contraction, a proof of the independence of the processes "contraction" and "retraction."

The uterine wound was now stitched in a careful and deliberate manner with No. 3 antiseptic silk interrupted sutures. These were placed at close intervals and were not drawn too tightly. A tear had taken place during the extraction of the child, which extended some distance from the original incision and required more than ordinary care in its closure. The uterus contracted well, stimulated by hot towels, and the abdomen was closed in three layers—peritoneal, fascial of continuous silk, and a subcuticular cutaneous of silkworm-gut. Throughout the operation rubber gloves were worn by all.

The puerperium has been quite uneventful. The suture was removed on the fourteenth day, leaving a perfectly healthy scar, and the patient has been able to nurse her baby from the third day.

## Transactions of Societies.

### ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD NOVEMBER 25TH, 1904.

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

THE PRESIDENT exhibited a small "VILLOUS TUMOUR OF THE BLADDER."

A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER.

Dr. W. J. THOMPSON stated that E. B. was admitted to Jervis Street Hospital on August 24th, 1904, a few weeks after her confinement, and suffering from jaundice one week. She was *æt.* 27, married six years, had three children; her family and personal history were good; had a hard life and lived in a tenement house in a congested part of the city. On admission, case seemed an ordinary catarrhal one; no enlargements of liver, all the organs normal, urine contained a slight trace of albumin. She seemed to improve the first week, but got worse during the second week. Nausea became almost constant and acute; sharp, spasmodic pains in liver became severe. During third week liver dulness greatly diminished. Leucin and tyrosin were detected in the urine, and at same time urea was diminished. At end of third week severe nervous and cerebral symptoms developed and she died three days afterwards, four and a half weeks after first sign of jaundice. At the *post-mortem* examination the liver was found to be small and soft, and only weighed 29 oz. All the abdominal organs were in a healthy condition, save for a small ovarian cyst. The clinical points of interest are: (1) The protracted length of the attack, four and a half weeks; (2) the acute, spasmodic, and agonising liver pains; (3) no hæmorrhagic manifestations.

Prof. E. J. McWEENEY then described the character of the specimen as follows: Liver weighing 29 oz., small, very soft and pulpy; capsule wrinkled, pale red with yellowish mottlings. On section, mostly reddish with bright yellow patches, lobular marking obliterated. Dimensions of right lobe, 6 in. from side to side,  $5\frac{1}{2}$  in. from before backwards,  $1\frac{1}{2}$  in. thick. The left lobe was at most only half an inch thick. Gall-bladder normal. The microscopic examination was made by means of teased preparations, frozen and paraffin sections. It showed complete necrosis of the liver cells; patches of round-cell infiltration, which still preserved their nuclear staining; patchy pigmentation of the liver cells with yellow granular matter which did not give an iron reaction (bile); moderate fatty degeneration; and the presence of minute, yellowish-brown globular concretions in groups and rows. These were very abundant in the tissue, and varied from  $12\mu$  to  $30\mu$  in diameter. Some of them seemed radially cleft, others were coated with a prickly layer of minute needle-shaped crystals, whilst others presented obscure concentric striation. There were also minute colourless acicular crystals lying singly and in sheaves. These objects were doubtless crystals of leucin and tyrosin. The globules were soluble in alkalis and weak  $H_2SO_4$ ; insoluble in ether, alcohol, and chloroform; partly soluble in water. A few bacilli were demonstrable on the sections, and of the numerous culture-tubes inoculated, a few showed colonies. Study of the organisms, however, convinced him that they were merely ordinary putrefactive germs.

Prof. O'SULLIVAN said he remembered one case of the kind, which belonged to Dr. Wallace Beatty. He had some sections of it which resembled those shown considerably, but his were more advanced. He was not sure that he would have taken Prof. McWeeney's view of the condition of the liver cells, as he did not think the process was very far advanced. There was certainly not so much disintegration shown in the sections as in those of the case in his possession. The process seemed to be starting from the hepatic veins, the portal areas being less affected.

The PRESIDENT had seen portions of a liver from an undoubted case of this disease. There was a large

portion of the right lobe involved, and on section of this, more than half the affected portion was a brilliant red colour, and the rest an equally brilliant yellow. In the red area the liver cells had disappeared, and in the portal canals there was small round cell infiltration. In the yellow areas were cells which looked absolutely normal. He was surprised at the small amount of fat he found in the cells. He noticed in some parts of the yellow areas, where they bordered on the red, that the centres of the lobules were certainly more affected than the margins. The process seemed to be progressing from the centre of the lobule to the periphery.

Prof. McWEENEY, in replying, said he considered that the cells were completely necrotic, though their outlines were preserved. They did not give the ordinary nuclear stain. The protoplasm had stained diffusely with hæmatoxylin stain. The preparations showed no well-preserved liver cells. The yellow pigmentation was well marked in one of the sections. The bacteriology of these cases was very interesting, because it was very important to eliminate the theory of living bacteria. The generally accepted theory was that it was due to toxins. He had set going a number of aerobic and anaerobic cultures, but the material was not perfectly fresh. The anaerobic tubes remained sterile, and the aerobic showed some small white colonies which he considered unimportant. He cut some sections in paraffin, and found an occasional bacillus, which he thought were ordinary putrefactive organisms. He thought the toxæmia theory still held the field.

#### GLANDERS.

The SECRETARY (for Dr. E. F. STEPHENSON) read notes of a fatal case of "Glanders in a Man."

Mr. STORY and the PRESIDENT exhibited a "Glioma of the Retina," with microscopic sections.

#### GLIOMA OF RETINA.

Dr. MOONEY exhibited a specimen which was a right eye removed from a female child, *æt.* 3, for glioma retinae. Four months before admission to the Children's Hospital, Temple Street, the eye squinted, and for four weeks the pupil had been white and eye blind. The eye showed no irritation, nor was there pain, although the tension equalled + 2. No proptosis. Microscopically, the tumour showed usual appearances, much of it being necrotic and fluid, with spots of hyaline degeneration. The optic nerve was wholly invaded by gliomatous cells up to point of section, only the fibrous trabeculae remaining.

Prof. McWEENEY said he never saw a prettier example of infiltration of the optic nerve. The resemblance between the cells of the tumour and the nuclear cells of the retina was very striking. He agreed as to the rarity of finding tubes lined with epithelium. These tumours, when not necrotic, were formed of small, round nuclei, broken up here and there by patches of necrosis. In Dr. Mooney's case patches of hyaline degeneration could be seen. It was not so well marked in Dr. Earl's case.

Prof. O'SULLIVAN thought the resemblance to angio-sarcoma was due to the fact that the cells in the neighbourhood of the vessels were well nourished, while those away from them were not and therefore became necrotic. This should be borne in mind in examining all cases of angio-sarcoma. The cells thus seemed to exist as tubes round the vessels.

Dr. MOONEY, in replying, said he had omitted to mention that there were some calcareous spots in his specimen.

The PRESIDENT, in replying, said he agreed with Prof. O'Sullivan as to necrosis occurring in those cells which were far away from the vessels.

#### HÆMATOLOGICAL OBSERVATIONS ON A CASE OF MYELÆMIA.

Prof. E. J. McWEENEY described this case, and exhibited the spleen and bone-marrow, as well as numerous blood-slides and sections of the various organs. The patient was a man, *æt.* 41, an inmate of Mullingar District Asylum for the past six years, suffering from paranoia with hallucinations and delusions. After four years of good bodily health he began to lose weight and became unable to work. A large

abdominal tumour was then discovered and recognised to be the hugely enlarged spleen. Blood counts yielded reds, 2,680,000, and whites, 450,000. Despite rest in bed, good food, and open air, he became steadily weaker. There was slight fever. Anæmic symptoms never prominent, and hæmorrhages did not supervene till a few days before death, when he suffered from epistaxis and hæmorrhagic effusion into subcutaneous tissue of right thorax. The duration of the case from the discovery of the splenic tumour was fourteen months. The autopsy revealed the following chief points: Enormous enlargement of the spleen, which weighed 145 oz., was firm, dark red and homogeneous on section, and presented neither hæmorrhages, infarcts, nor whitish infiltrations. Marrow of long bones pink, fleshy, vascular, completely altered from its normal fatty state. Superficial lymph-glands not enlarged. Of the internal ones, the bronchial, omental, mesenteric, and celiac were slightly enlarged. There was slight obsolete tubercle in both apices. The liver weighed 138 oz., but showed no macroscopic change beyond slight nutmeg discoloration and marked hyperæmia. No leucæmic infiltration in any of the organs. The results of the histological examination were then given. Blood-films taken shortly before death showed: Polymorphs, 35 per cent.; myelocytes, 45 per cent.; transitionals, 3.5 per cent.; small lymphocytes, 2 per cent.; eosinophiles, poly and mononuclear, 14.5 per cent. A certain number of mast-cells were seen, and polymorphs with mitotic nuclei were readily found in the peripheral blood. Marrow films revealed giant-cells, myelocytes, eosinophiles of both kinds, large and small hyaline mononuclear and normoblasts in varying proportions. Megaloblasts were very few, and that class of cell was represented by forms with nucleus and discoplasm of megaloblastic type, but smaller than an ordinary red corpuscle. The speaker expressed his deep sense of obligation to Dr. A. Finegan, Resident Medical Superintendent of Mullingar Asylum, for permission to bring the case forward, and to Dr. W. S. Gordon, Assistant Medical Officer, for the very full clinical notes of the case.

Prof. WHITE said that the point which interested him most was the section which showed what was probably mitosis. He was convinced of the fact that mitoses did occur in the circulating blood under certain conditions.

Prof. O'SULLIVAN suggested the possibility that the giant-cells in the liver capillaries might have been marrow cells carried there.

Prof. McWENEY, in replying, said that the giant-cells were products of the endothelium.

#### NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT SHEFFIELD, NOVEMBER 18TH, 1904.

DR. R. FAVELL, Vice-President, in the Chair.

THE Society passed a unanimous vote of hearty congratulation to the President, Sir William Japp Sinclair, on the honour recently conferred upon him by H. M. the King.

Dr. J. B. HELLIER, whilst showing a myomatous uterus removed by abdominal hysterectomy, mentioned that although the operation presented no difficulty and the patient made a good recovery, without any suppuration, an interesting complication occurred on the second morning after operation. The temperature rose to 100.6°, and the pulse to 140; there was acute abdominal pain with distention and hiccough, and a turpentine enema brought no relief. The distension was chiefly at the upper part of the abdomen, and it was therefore decided to wash out the stomach. On passing the stomach tube there was an immediate escape of gas, a large quantity of mucus was removed, and immediate relief was obtained. The lavage was repeated in the evening, and the symptoms abated from this time.

Dr. J. E. GEMMELL (Liverpool) read a short paper on a case of

#### CÆSAREAN SECTION FOR MYASTHENIA GRAVIS.

The case had been referred to him by Dr. W. B. Warrington, Physician to the Northern Hospital, who had described it from the physician's point of view in the *Medical Chronicle* for April, 1904. Dr. Gemmell remarked that the clinical feature of the disease is muscular weakness of some or all of the voluntary muscles, sometimes amounting to paralysis. After a prolonged rest these same muscles may respond to the will, but they again become rapidly exhausted. Soon after the patient's admission to the Northern Hospital it was found that she was pregnant, and that as the pregnancy advanced the disease became worse, until physical exertion of the slightest kind produced the greatest exhaustion and led to the onset of alarming dyspnoea. Labour was expected about October 20th, and the patient was admitted to the Lying-in Hospital on October 15th. During the first twenty-four hours she had four attacks of dyspnoea, each lasting five minutes, whilst for the first forty-eight hours she scarcely slept at all. Dr. Warrington had pointed out that if the patient did not succumb during the first stage of labour, attempt at the use of the secondary powers in the following stage would almost certainly bring on a fatal attack of dyspnoea. Dr. Gemmell decided to await the advent of labour and act as occasion might require. However, the dyspnoea increased in gravity, and on October 18th, it was found that the only respiratory movements were those associated with hiccough. Cæsarean section, as the speediest means of delivering the patient, was decided upon. The operation was rapidly carried out without any difficulty, and was followed by uninterrupted recovery and gradual improvement of the respiratory symptoms. Dr. Gemmell remarked that he had been unable to find any reference to the effect of parturition in advanced cases similar to this one. One patient with ocular paralysis became pregnant and became practically well of the paralyses. Another developed the disease when six months pregnant, improved, and then is recorded as a typical case three years later.

Prof. ARTHUR J. HALL (Sheffield) thought that the right and proper treatment had been carried out, and remarked that such an event as Cæsarean section was probably unique in the annals of myasthenia gravis. He referred to the rarity of cases of this disease, and to the constancy with which they were usually diagnosed as hysteria in their earlier stages, chiefly because of the extreme variability of the symptoms from day to day, or even from hour to hour. In a fatal case of the disease which he had recorded a few years ago in *Brain*, this variability was a striking feature: at one time the patient would walk fairly well, at another she would hardly be able to stand. After a sleep she would be able to speak clearly and to open the eyes widely, whilst as the day went on, her voice would become nasal and there would be marked ptosis. Even the sudden death of the patient from respiratory failure followed a day after she had seemed better than she had been for weeks.

After further discussion, Dr. GEMMELL said that the anæsthetic employed had been chloroform, very little being required. If such a case had been met with in the earlier stages of pregnancy, it would have been proper treatment to cut short the gestation.

Dr. JOHN W. MARTIN (Sheffield) read notes of a case of

DOUBLE OVARIAN PAPILLOMATOUS CYSTIC TUMOURS, with a large fibroid springing from the fundus uteri. The points of interest were: (1) There was not much ascitic fluid found on opening the abdomen; (2) the ovarian tumours followed the ordinary rule in being bilateral; (3) the right ovary was as large as any ordinary cystic adenoma of the ovary, papillomatous tumours as usually described being smaller; (4) there was no peritoneal infection, although the papillomatous growth had penetrated the wall of the right-sided tumour.



Dr. LLOYD ROBERTS commented on the absence of ascites and on the question of malignancy.

Dr. GEMMELL remarked on the frequency with which ovarian new growths and inflammatory conditions complicated fibroids of the uterus.

Dr. PERCIVAL BARBER (Sheffield) read notes of the following cases:—(1) Fibroma of the Abdominal Wall, which was removed from a woman, *æt.* 27. In the space of three months it had increased from the size of a small nut to a lump measuring 2½ by 1½ inches. It was situated about two fingers' breadth internal to the right anterior superior iliac spine. Removal was easy. (2) Ectopic Gestation. (3) Rupture of Uterus, which occurred in a very obese woman, *æt.* 32, who was sent into the Jessop Hospital after labour on account of a supposed rupture of the vaginal wall. Forceps having failed, the delivery had been effected by version. When Dr. Barber saw the patient she was comfortable, the temperature 102°, pulse-rate 126. Abdominal examination disclosed nothing unusual, the uterus being firmly contracted. Vaginal examination was difficult by reason of the patient's size, but no vaginal tear could be discovered. The cervix was ragged and a tag hung down from it. The urine contained a little blood at first, but none later. All day the condition remained good, but pneumonia developed at night. Next morning, after an action of the bowels, the patient became very ill and died in a few minutes, without exhibiting the classical signs of internal hæmorrhage. Autopsy on the same evening: Stomach and intestines greatly distended by gas; no evidence of peritonitis; the abdomen contained much free recent blood; blood was found also in both broad ligaments, chiefly in the right; a complete rupture of the uterus ran obliquely upwards from right to left, involving the lower uterine segment principally; Bandl's ring was very conspicuous.

#### THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

At a meeting held on November 18th, Mr. ROBERT JONES in the Chair, twenty-one new members were elected. The Glas-Sedilbanck lamp for the cure of lupus was demonstrated.

A specimen of "Congenital Atresia of the Tricuspid Valve" was shown by Dr. BERTRAM ROGERS (Bristol) and Dr. J. M. FORTESCUE-BRICKDALE (Bristol). The child, *æt.* 2, was admitted into the Children's Hospital, Bristol, suffering from bronchitis with extreme dyspnoea and cyanosis. The fingers and toes were clubbed, and the lips and extremities deep purple. There were no cardiac bruits and no apparent increase of cardiac dulness. She had suffered from repeated attacks of cyanosis. She died in a few hours. *Post-mortem*, the heart weighed 3½ oz. When opened it showed hypertrophy and dilatation, mostly of the right auricle and left ventricle, patent foramen ovale, atresia of the tricuspid orifice, and a small opening between the ventricles. There was no sign of endocarditis; the ductus arteriosus was closed.

A specimen of "Congenital Pulmonary Stenosis" was shown by Dr. GEORGE CARPENTER. The condition was associated with a perforated septum ventriculorum and a patent foramen ovale. The aorta in great part arose from the right ventricle. The heart was removed from a child, *æt.* 2, free from other congenital abnormalities. The right ventricle was hypertrophied and during life this was an obvious feature. There was a loud systolic murmur audible all over the pericardial area and of maximum intensity at the xiphoid; it was inaudible in the great vessels of the neck and only occasionally heard in the back. The lips were cyanosed, and the fingers and toes blue and clubbed. The child was born blue, and the cyanosis had latterly increased—she had twice been convulsed. The red corpuscles were 7,800,000 per cm., and the hæmoglobin 122 per cent. She died of measles. Dr. Carpenter drew attention to the large increase in the number of red corpuscles and of the hæmoglobin percentage, which in his experience was not an uncommon feature in cases of congenital morbus cordis with cyanosis. He also commented on the value of

the skiagram in such cases, and on the early advent of cyanosis. The absence of a systolic bruit in the great vessels of the neck was touched upon, and its value when audible there as a diagnostic sign of the condition of perforate septum ventriculorum was, he thought, of considerable importance.

A specimen of "Atresia of the Pulmonary Artery" was also shown by Dr. SYDNEY CURL.

A case of "Juvenile General Paralysis" was shown by Dr. JAMES TAYLOR. The patient was a boy, *æt.* 11½, the fifth in a family of nine, all said to be healthy. He was born at full term, suffered from abscesses "in the head and groin" at 1, but did not walk till he was 4. At 6 he developed a faculty for romancing, telling wonderful stories apparently merely to excite admiration. He was also frequently violent and vicious. The physical signs and the mental symptoms, slight as they may be, appear to indicate definitely that the case is one of juvenile general paralysis, and the physical and mental degeneration are likely to become much intensified.

A case of "Bell's Paralysis with a Hemiplegic Onset" was shown by Dr. J. PORTER PARKINSON. The boy, *æt.* 4, had been perfectly healthy till July last, when paralysis in the right arm and leg and left side of the face occurred suddenly. The weakness of the arm and leg passed away in a week, and, when examined, there remained only weakness of all the left side of the face. Dr. Parkinson thought the case due to a lesion of the nucleus of the facial nerve involving the pyramidal tract in some temporary manner, possibly passing oedema, and, from the sudden onset during the summer, with hyperæsthesia, in a previously healthy child, it resembled the lesion known as encephalitis inferior, pathologically similar to acute anterior polio-myelitis.

A case of "Ataxy of the Cerebellar Type" in a girl *æt.* 4, was shown by Dr. PORTER PARKINSON. The condition of the fundi of the eyes suggested it was a degeneration occurring in hereditary syphilis, though there was no other evidence, personal or family, to corroborate this.

A case of "Progressive Palsy" in a boy, *æt.* 13, was shown by Dr. HARRY CAMPBELL (introduced). The paralysis began in the legs at the age of five years, and was noticed in the hands at the age of nine, and in the face at the age of ten. It was symmetrical, and in the extremities mainly confined to the long extensors. Electrical reactions were normal. Dr. Campbell was uncertain as to the nature of the affection.

Three cases of "Unilateral Congenital Dislocation of the Hip" of varying degrees of severity were shown by Mr. DOUGLAS DREW.

A case of "Old-standing Dislocation forwards of the Head of the Radius," of two years' duration, was shown by Mr. DOUGLAS DREW. The dislocation was reduced by operation, but in spite of the greatest care the condition recurred. Inasmuch as the function of the arm was little impaired and the deformity was trifling, Mr. Drew advocated no further interference.

Two cases of "Cephalhæmatoma Neonatorum over the Occipital Bone" were shown by Mr. J. HOWELL EVANS, who subsequently gave a lantern demonstration on the subject. Mr. Evans considered these blood effusions were due to a reactionary hæmorrhage from a small artery which had been injured in the moulding of the infant's head during its passage through the birth-canal. Foetal skulls and many lantern slides of the skulls of various animals were shown to illustrate Mr. Evans' views. The author advocated the immediate surgical treatment of cephalhæmatoma neonatorum.

A case of "Graves' Disease" in a boy, *æt.* 12, was shown by Mr. SYDNEY STEPHENSON. The thyroid was enlarged, there was slight tachycardia, slight exophthalmos, and a curious pallid puffiness of each upper lid. There were no nervous symptoms.

Two cases of "Traumatic Keratitis following Difficult Instrumental Labour" were shown by Mr. SYDNEY STEPHENSON.

A specimen of a "Tuberculous Fallopiian Tube" and

"Tuberculous Ulcers of the Intestine," removed from a case of general tuberculosis, *æt.* 2½, was also shown by Dr. SYDNEY CURL. It was not suspected during life. The uterus and ovaries were healthy.

The cases were discussed by Mr. Robert Jones, Dr. Edmund Cantley, F. Parkes Weber, C. W. Chapman, G. A. Sutherland, C. O. Hawthorne and Mr. L. McGavin.

#### NORTH-EAST LONDON CLINICAL SOCIETY.

CLINICAL EVENING HELD THURSDAY, DECEMBER 1ST, 1904.

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

DR. J. W. HUNT showed a middle-aged woman with an Innominate Aneurysm which had existed for two years without causing any deterioration of health.

The PRESIDENT exhibited (1) a case of Hæmo-Pneumothorax in a man, *æt.* 30, the origin of which was doubtful. The pneumothorax was limited to the upper part of the left chest. On aspiration of the base about half a pint of dark blood was withdrawn. The heart was considerably displaced towards the right, and there was a small band of hyper-resonance above the stomach due to a layer of compressed lung. The early symptoms presented by the patient were more abdominal than thoracic in character, resembling those of diaphragmatic pleurisy. All the ordinary causes of this affection could be excluded.

DR. HERBERT P. MILLER referred to a case which had been under his care in which the diagnosis of hæmo-pneumothorax was proved by the fact that paracentesis had been performed twice, and on each occasion blood was withdrawn. The patient made a complete recovery.

(2) A case of Actinomycosis in a man *æt.* 36 (through the courtesy of Dr. H. Cuff, Medical Superintendent of the North-Eastern Fever Hospital). The condition affected the left side of the face, inferior maxilla, and buccal mucous membrane. The typical ray-fungus was obtained microscopically.

MR. HERBERT CARSON emphasised the importance of giving very large doses of potassium iodide in such cases, and referred to the difficulty sometimes experienced in distinguishing actinomycosis from early cases of malignant disease.

MR. R. F. TOMLIN showed a case of Raynaud's disease in a middle-aged woman.

DR. J. A. WHITING showed an in-patient at the Tottenham Hospital, the subject of an Aneurysm of the Ascending Aorta. The patient was a man, *æt.* 48, and the aneurysm was visible externally as a tumour the size of a goose's egg, situated to the right of the upper end of the sternum.

The PRESIDENT remarked that the sac was probably well-filled with clot, as a murmur could only be faintly heard over it. He considered that the case was a suitable one for attempting a cure by the introduction of silver wire.

MR. WALTER EDMUNDS thought that surgical interference was for the most part impracticable in aneurysms of the aorta, but in the case of innominate aneurysm exhibited the effect of the distal ligature might be well worth considering. The treatment of gelatine injection was sometimes open to fallacy, as the improvements reported after its use might conceivably be due to the enforced rest in bed to which the patients had to submit. Mr. Edmunds also exhibited (1) a boy, *æt.* 13, upon whom he had operated for Ruptured Liver. A collection of bile had re-formed shortly after the operation. There was very little hæmorrhage.

DR. WHITING asked whether this case might not have been an example of the condition known as "bile-cysts," and referred to a case reported by Mr. Alban Doran, in which operation was performed three years after an injury to the right hypochondrium.

(2) A boy, *æt.* 12, from whom he had excised a growth of the inner end of the left clavicle. The appearances

at the time of the operation suggested an endosteal sarcoma.

DR. DAVID McASKIE showed a case of Splenomegaly Leukæmia in a man, *æt.* 38. He had been treated with arsenic for seven weeks, but subsequently he had had the X-rays applied twice a week. Before the latter treatment was commenced the blood-count was as follows:—red cells, 3,000,000; white cells, 392,000. Three weeks afterwards the leucocytes had diminished to 40,000, and the spleen was lessened in size to the extent of two inches. Of late a little perisplenitis had developed. The large mono-nucleated leucocyte predominated.

MR. CARSON showed a Cyst of the Tongue which he had removed from the case exhibited at the last meeting of the Society by Dr. F. Tresilian, and which proved to be a sequestration-dermoid, there being no connection with the thyroglossal duct.

DR. ARTHUR E. GILES exhibited a specimen of an Ossified Fibro-myoma Uteri. The patient was a woman *æt.* 65, in whom a hard tumour could be felt present at the external os. The capsule around it was sloughing, giving rise to a most offensive vaginal discharge. In spite of the narrowness of the vagina, it was decided to attempt the removal of the mass by that route. The operation was attended by no small difficulties on account of the hardness of the tumour and the constriction of the natural passages. The fibroid was ultimately extracted after splitting the cervix and parts of the posterior vaginal wall, and rotating the tumour upon its long axis. The mass weighed 15 oz. The patient made a good recovery.

#### THERAPEUTICAL SOCIETY.

MEETING HELD NOVEMBER 22ND, 1904.

SIR LAUDER BRUNTON, President, in the Chair.

THE SECRETARY read a paper by Dr. GORDON SHARP of Leeds, who was unable to attend, on  
STRYCHNOS TOXIGERA AND OTHER PARALYSERS OF MOTOR NERVE ENDINGS.

He said many had endeavoured in vain to discover the plant that produced curarine, until Mr. J. Quelch brought him, in 1902, some poisoned arrows and specimens of the plant given him by an Indian chief of Guiana. The plant was found by Mr. E. Holman to be the *Strychnos toxigera* (Benth), and curarine was found in the bark, but not in the leaves. This alkaloid is very deliquescent and easily decomposed—its salts are more stable; commercial curarine contains 9 to 11 per cent. of the alkaloid. Curare has been used in chorea convulsions, and to prevent painful spasms in moving wounded persons. He compared its action with that of strychnine, delpho-curarine, alstonine, aconite, snake-poison, and diphtheria toxin.

The PRESIDENT said that the paper reminded him of one by Majendi, on the upas poison, which was *strychnos nux vomica*. He thought alstonine might be useful in cases of excessive itching in diabetes and albuminuria.

DR. CRICHTON remarked that death from curare in frogs occurred only after forty hours, while strychnine killed them in two hours.

MR. G. C. MOOR, F.I.C., F.C.S., read a paper, entitled  
NOTES ON BRANDY,

showing that the different constituents in brandy could be accurately estimated by chemical analysis, but it was quite possible to prepare a brandy which would answer every analytical standard and yet not be brandy as understood and prescribed by the medical profession. Therefore brandy factories should be properly inspected by Government, as is done in Australia with the Orion brandy exported to this country.

SIR LAUDER BRUNTON remarked that the effects of wines were very diversified. Some promoted merriment, others quarrelsomeness, but it was impossible to say on what this depended, and the same results probably followed on the imbibition of various brandies, whether pure or adulterated.

Mr. McEwen said that nine-tenths of the brandies met with were not really brandy at all, but a mixture. Ether could easily be added to silent spirit and form a good imitation.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, December 4th, 1904.

### TREATMENT OF DYSMENORRHOEA.

EVERY practitioner knows how painful and troublesome dysmenorrhœa is, and the following counsel given by M. Dalché on the affection may be useful.

The first thing to be done is to discover the cause of the malady. Constipation should be avoided as well as intellectual and physical fatigue. To ease the pain, simple means may be at first enjoined—rest, warm applications, belladonna suppositories. An enema may be given in the morning with:—

Antipyrine, 15 grs.;  
Laudanum, 20 drops;

or the following ointment:—

Extract of hyoscyamus,  $\frac{1}{2}$  dr.;  
Extract of belladonna,  $\frac{1}{2}$  dr.;  
Vaseline, 1 oz.

As to applications of ice, recommended by some, they are dangerous, for if they ease the pain they may arrest the flow of blood. A German author, Fliess, having found that there existed regions of the mucous membrane of the nasal fossæ constituted of erectile tissue, remarked that when the ovary became turgescient the mucous membrane of the nose was similarly affected. Hence he wanted to endeavour to calm the pain of dysmenorrhœa by touching the nasal cartilage with a solution of cocaine and with some success.

M. Dalché tried the method of Fliess with satisfactory results in some cases.

When the blood is normal in quantity at each period, antipyrine should be prescribed in 15 gr. doses, associated with 10 grs. of bicarbonate of soda, or 6 grs. of pyramidon. Dr. Huchard recommends:—

Tincture of piscidia erythrina, 10 grs.;  
Tincture of viburnum prunifolium, 10 grs.

Twenty drops four or five times daily.

For lumbar neuralgia, ichthyol externally is very efficient.

Ichthyol, 2 dr.;  
Chloroform, 3 dr.;  
Camphorated spirits, 2 oz.

Between the periods cannabis indica should be prescribed.

If the flow was excessive (menorrhagia), the fluid extract of hydrastis canadensis is indicated (20 drops three times a day). If, on the contrary, the flow is insufficient or slow to appear, general tonic treatment should be ordered with ovarian opotherapy.

Where the menses are entirely irregular, cold bathing, corporal exercise, gymnastics, and ovarian opotherapy will render good service. Marriage might also be recommended.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 4th, 1904.

At the Society for innere Medizin, Hr. Hirschfeld discussed

### THE PROGNOSIS OF DIABETES.

He said that in general diabetes was divided prognostically into two groups—into the grave, which was distinguished by the appearance of sugar in the urine even where no carbohydrates were given in the food, and into the mild, in which this was not the case. The grave form ended fatally within five years; the mild, on the other hand, with favourable conditions of life, and with suitable feeding, &c., led to no great shortening of life. This view had been given expression to by Naunyn, and it had been generally agreed to. According to the speaker, this was not correct;

according to his observations a portion of these milder cases died during the first ten years of the disease. The cases of the mild group were not all alike; the amount of sugar was of great importance; the urine should be examined for months, in order to ascertain how much carbohydrates could be digested. According to this the speaker divided this group again into two groups: First, the cases that from 100 grammes of carbohydrates excreted 20 to 25 grammes of sugar, and second, those that from the same quantity excreted 10. In the first group nephritis came on between the 4th and 7th years, and between the 40th and 55th year of life. Polyuria, adiposity, nephrolithiasis and cystitis all appeared to favour the development of nephritis. The nature of the nephritis was not yet clear. The speaker thought it was a chronic parenchymatous nephritis and not one from arterio-sclerosis. As regarded diet, he rejected milk, but recommended cream, and a diminution of the quantity of flesh. Outside of nephritis the causes of death in the middle group were coma, apoplexy, cardiac weakness, and, rarely, gangrene and tuberculosis. Few of these cases died of intercurrent diseases.

At the Gesellschaft der Charites-Aerzte, Herren Mossen and Milchner spoke on the

### TREATMENT OF BLOOD DISEASES BY THE RÖNTGEN RAYS.

The X-rays destroyed the follicles in the spleen and the lymphatic glands just as in the medulla of bones, as experiments on animals had proved. The white cells were influenced whilst the cells containing hæmoglobin were resistant. In so far the X-rays exercised an electric action. This discovery was opposed to the assumption that both sets of cells were from a common stock. Eczema or injury to the roots of the hair was never observed in the animal experiments. Preparations of blood and bone marrow were shown.

Hr. Krause had seen failure in a case of mixed-celled leucæmia. Hr. Gorawitz observed that all erythroblasts did not originate out of a white preliminary stage; most were found by homoplastic increase. In a case of leucæmia he saw a surprising result from the X-rays.

Hr. Kaiserling observed that after the destruction of the follicles mentioned there was a remarkable regeneration.

Hr. Senator had seen marked diminution of the spleen in three cases after application of the rays.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, December 3rd, 1904.

### GAS CYSTS IN THE BRAIN.

At the Prague meeting, Chiari raised a discussion on multiple spaces in the substance of the human brain, without any lining or covering to indicate a cavity produced by fluid. Clarke gave it the name of the Swiss cheese brain, from its appearance to that article of diet. Reuling and Herring, in 1899, came to the conclusion, after many experiments, that the cavities were formed by the accumulation of gas produced by the bacillus aerogenes. Since that time, many interesting cases have been published, while the brain substance has been preserved by hardening with formol, and sections thereafter made to demonstrate the lamellæ of the cyst. Chiari reported five cases that he had seen himself since 1893, two from typhoid, one from Bright's disease, and two from sephthæmia or septicæmia. These cysts were demonstrated on *post-mortem* and after hardening. In one of the sephthæmia cases large emphysematous cavities were found in the subcutaneous, intermuscular, mediastinal, and sub-peritoneal cellular tissue, as well as the presence of typanites uteri. The streptococci pyogenes of puerperal females produce the same results as those of the *aerogenes capsulatus reni*, which have been cultivated

In a brain suffering from the latter, one-half was cut into sections, but no cysts could be observed; the other half was hardened in formol, with the result that after two months beautifully laminated cysts could be found with the corresponding bacteria. This was also the case in one of the sephthæmia cases.

#### EHRLICH'S COLOUR REACTION.

The red colour of urine with a salt of dinnethyl-amin-benzol-aldehyde (Ehrlich) depends upon the presence of urobilin or its derivatives. Although this may not be pathognomonic, it indicates the presence of pyrrol, which, according to Nencki and Zaleski, forms the colouring matter of the tissues. Its pathology in the urine is to be found in cases of pneumonia, blood diseases, and hepatic disorders in which the reaction is very much accentuated from the normal conditions. The absence of this reaction in the urine is to be found in cases of icterus, where the choledochus and hepaticus is closed. The gall secretion gives a red colouring with the aldehyde, because it contains the urobilinogen. This aldehyde reaction is also found in the fæces, where indol, skatol and urobilinogen are present. Hæmopyrrol, which is found in all blood colouring matter, and is therefore present in most of the albuminous secretions of the body, with the exception of gelatine or gluten is too comprehensive to be of any real value in the diagnosis of any individual disease, although Ehrlich himself contends that there are various shades of colours produced with concentrated sulphuric acid that give a violet colour when the indol group is present with a molecule of albumin. The aldehyde may be considered a reagent for all the pyrrol derivatives. The red colouring is not confined to the acid form, as acetyl-glycos-amin, when treated with an alkali, and the aldehyde produces the red colour also.

#### ALKAPTONURIA.

Falta treated the audience to a long history of a case of alkaptouria, which is the morbid elimination in the urine of a uroleucin salt, sometimes designated hæmogenitisin. This substance is often present in healthy children as well as in cases of diabetes and phthisis, and can be detected by Fehling's solution. It would seem from Falta's observation that hæmogenitisin is obtained in small quantities from albuminous bodies, and may be recognised as an amino-complex salt and eliminated in a form of alkaptouria. The administration of bromine and iodine checks the elimination in the urine by their action on the albuminoid molecule. It is therefore a specific change when this hæmogenitisin is produced, as the whole disturbance is located in the structure of the albuminoid molecule. Langstein said that he always considered hæmogenitisin to be closely allied to tyrosin, which he had obtained from plants as an experiment with phenylalanin with sections of turnips, whose ferment will produce the so-called hæmogenitisin salt. Klemperer asked if there had been any hereditary conditions to cause alkaptouria in Falta's cases, as consanguinity was often found to be present in these cases. Falta said that neither consanguinity or hereditary could be proved.

#### HIS AND WEIGERT.

The journals this week contain long records of the scientific work of these two investigators. His was known in anatomy and embryology, and his works have now become classic. Born in Basle, 1831, he studied under Müller, and Remak, and became professor of anatomy in his own university in 1857. Weigert died rather suddenly in his fifty-sixth year. His investigations lay in the examination of the secretions and blood circulation according to Cohnheim's views, and he finally devoted the whole of his time to bacteriology and histology in conjunction with Koch and others. His methods of colouring sections will long be remembered by students of medicine.

## The Operating Theatres.

### ROYAL FREE HOSPITAL.

OPERATION FOR TRAUMATIC EXTRA-DURAL HÆMORRHAGE.—Mr. T. P. LEGG operated on a man, æt. 35,

who had fallen on to his head whilst riding a bicycle. He was unconscious for a moment, but recovered quickly and rode on home, a distance of about half a mile. He went to bed at once and complained of a good deal of headache, especially in the frontal region. There was considerable epistaxis, and the left eye was proptosed. He was sick once or twice, and remained unconscious for some hours; then he became quite unconscious about twelve hours after the accident. On admission, he could not be roused, his breathing was not stertorous, his pulse was 54, full and regular. The pupils reacted very slightly to the strong light, the left pupil being somewhat larger than the right. There was a superficial excoriation over the left eyebrow, and a large hæmatoma around it extending into the eyelids of the same side. On separating the left eyelids an extensive sub-conjunctival hæmorrhage was found on the outer side of the globe of the eye. The right arm and leg were paralysed, and dropped when raised more quickly than the left arm and leg; both knee-jerks were present. There were no other injuries. A diagnosis of fissured fracture extending into the base of the skull through the anterior fossa, leading to extra-dural hæmorrhage, was made and immediate operation undertaken. A large flap consisting of the whole of the structures of the scalp was turned down from the temporal and frontal regions of the left side; the fissured fracture was then seen running vertically downwards in the frontal bone a short distance behind the external angular process, and one or two small fissures radiating from the main one. A 1-inch trephine was then used to remove the bone close to the main fissure; a large clot was at once exposed. The opening in the skull was rapidly enlarged by Hoffman's forceps and the clot removed by means of a Volkman's spoon. On the dura mater a small branch of the middle meningeal artery was found to be bleeding, and this was tied by running a suture underneath it. The clot extended downwards into the anterior fossa of the skull, and about four ounces of it were removed. The dura mater was seen to be pressed inwards so as to form a saucer-shaped depression; the brain could be felt pulsating as soon as the clot was removed; it at once began to expand as soon as the pressure of the clot on it was relieved, and the depression in the dura mater for the most part then became obliterated. Running across the anterior fossa, a fissured fracture was found passing from left to right, and somewhat backwards. The bone was not replaced, and two or three small pieces of gauze were placed in the space between the dura mater and the bone. The flap was sutured in position, a drainage-tube being inserted through a counter-opening in the middle of its base, the pieces of gauze being brought out at each end of the incision. Mr. Legg said that this was a typical case of extra-dural hæmorrhage, showing all the classical symptoms, namely, an injury and temporary loss of consciousness, recovery of consciousness, and then steadily increasing coma. The signs present were very characteristic, a slow pulse, which was of good volume and regular; the condition of the pupils and a hæmatoma of the scalp suggested the seat of the fracture and the place where any operation should be performed. The projection of the left eye was due to hæmorrhage behind it, and this, coupled with the epistaxis, suggested what was found to be a fact, that there was also a fracture of the base in the anterior fossa. As regards the operation,

a small amount of chloroform was required while the skin incision was being made; afterwards the operation was completed without any more anæsthetic. When the clot was exposed no pulsation was observed, which suggested that the hæmorrhage had naturally ceased, and when the clot was removed no recurrence of the bleeding took place, so that the actual source of the blood was not defined. The small vessel which was ligatured on the surface of the dura mater was unlikely to have been the source of so large a hæmorrhage, which, it was probable, came from a sinus at the base of the skull, and in order to prevent its re-accumulation, if any subsequent hæmorrhage took place, the gauze drains were placed inside the cavity. The bone was not replaced because the brain had not completely expanded, and, therefore, the pieces of bone might have become displaced and acted subsequently as a source of irritation. As regards the prognosis in these cases, it must be always grave. A certain number of patients do recover, but the majority, even when the hæmorrhage is capable of being dealt with and diagnosed as in this case, will die for these reasons: First, extensive injury to the brain itself leading to subdural hæmorrhage; second, the pressure to which the brain is subjected, and which prevents the brain expanding when the clot is removed: if this expansion fails to take place the patient invariably dies; and, thirdly, other injuries, as extensive fracture of the base of the skull.

The patient recovered consciousness five hours after the operation, and recognised that he was in the hospital. His pulse was 72 per minute, and otherwise normal; the right pupil reacted readily to light, and was normal in size. He subsequently made an absolutely uninterrupted recovery, and left the hospital in the fourth week after operation.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 7, 1904.

### INFANTS' HEALTH SOCIETY.

INFANTILE mortality is one of the chief socio-hygienic problems of the day. No single question is more worthy of study, for in the infantile death-rate are reflected all, or nearly all, the diseases of corporate national life. The extent to which infant mortality prevails expresses the sum of the

factors of intemperance, over-crowding, insanitary conditions, improper and insufficient food, parental neglect, and want of education. All these the infantile death-rate denotes, but it connotes more—namely, the measure in which the brothers and sisters of the dead children are being affected in mind, body, and estate by the same conditions. To medical men the influence on the rising generation of these conditions is, and has been for many years, painfully apparent, but for the most part their warnings, born of experience, have fallen on deaf ears. We are glad to note that now, before it is too late, these warnings are beginning to be heeded, and that in the "physical degeneration" scare which followed the South African War the facts brought to light have stirred a desire and a determination on the part of many influential and philanthropic people to tackle the problem in earnest. In the columns of the *Times* a series of bold, strongly-worded articles has been appearing dealing with the matter in various aspects, and the recent foundation of the Childhood Society and the Infants' Health Society, both of which include laymen as well as medical men among their members, also points to an amount of interest in the welfare of the young of poor parents that is very gratifying. It seems likely, then, that in the near future definite and concerted action will be taken to reduce by every practicable means a mortality and sickness amongst the infants of this country which may be characterised as a blot upon our civilisation. The matter, however, is not a simple one; it involves in reality the rectification of practically every social disadvantage and sanitary disability existing—a task that might well cause the stoutest heart to quail. The first and foremost necessity is for all engaged in the task to be well cognisant of the nature and extent and causes of the evil, and be thoroughly clear and unanimous as to the right line of procedure. Enthusiasm is good, but enthusiasm must be tempered with discretion. The Infants' Health Society, which was formed in February of this year, has placed before itself an ambitious task, and actuated as it is by an ardent desire to save the lives and improve the physique of the children of the poor we need hardly say that we are in entire sympathy with its main aims. This sympathy, however, must not deter us from offering a few friendly criticisms of the methods by which it proposes to work and the means which it proposes to adopt to attain its ends. The society has published a pamphlet setting these forth, and this pamphlet is now available for distribution to those likely to be influenced by it. It is to be regretted that the writer of this pamphlet in urging a good cause has allowed himself to be betrayed into hyperbole, and that instead of setting forth the sober facts—which are convincing enough in all conscience—he has allowed his pen to run into a certain extravagance. For instance, such a statement as that "among substitute-fed infants, it is becoming a comparatively rare thing to find a single case of healthy growth and development," is not likely to find endorsement in the experience

of those into whose hands the pamphlet falls. The bulk of town-bred children are wholly or partially substitute-fed, and fortunately there are still a good many healthy among them. Sweeping generalisations of this kind, and there are several similar ones, tend to endanger an excellent cause; good wine needs no bush. The society rightly insists on proper feeding in infancy playing a leading part in the avoidance of death and disease, and insists also on the undesirability of undermining parental responsibility in the up-bringing of children. It is true that great difficulty is experienced by employed women in nursing their children at the breast; but the importance of doing so whenever possible should be recognised fully by all enlightened endeavour. The question is largely one of education—the tradition of breast-feeding is dying out in many classes owing to a great extent to the cheapness of tinned milks and the fashion of babies' foods. These two points, the education of the mother and the encouragement of breast-feeding, are the greatest desiderata. Too much stress, we think, is laid by the society on the provision of milk depôts for the distribution of milk—free or for small payments. In the first place the cost of an organised system of depôts all over the great towns, such as they wish to institute, would be enormous, and in the second, it would militate against the principle of parental responsibility. The society would do well to direct their most strenuous efforts towards the reformation of the milk trade, so that the poorest could be assured of obtaining a perfectly trustworthy article of diet for their young. The modification of cow's milk to suit the human infant is not such a difficult matter as the society seems to think; it can be done easily by anyone if properly instructed, and the best way to aid in this particular is to urge local authorities to appoint female health visitors to educate and help ignorant mothers. The potentiality for good of such visitors is enormous, both in bringing to light parental neglect and in teaching those willing to learn, provided suitable women are chosen for the posts. We think that the society would be more likely to be successful if they worked on these lines than by embarking on a policy so expensive and difficult to maintain as that of the wholesale provision of milk depôts.

#### MICRO-ORGANISMS IN THE STOMACH.

It has long been recognised that an important function of the hydrochloric acid in the gastric juice is the destruction of bacteria ingested with the food. With every mouthful of food, particularly raw foods and cold meats, we swallow myriads of living organisms, yet it is probable that as long as a stomach is healthy but few of them pass the pylorus alive. On the other hand, any departure from health, such as ulceration, diminishes considerably the bactericidal power of the gastric juice or gives organisms such a firm foothold that its action is neutralised. Some observations and experiments recently made by Dr. Hewetson, of

Birmingham, (a) illustrate this in a conclusive manner. In a number of patients suffering from gastric dilatation, the opportunity of a gastro-jejunostomy was taken to obtain specimens of the gastric contents for bacterioscopic examination direct from the stomach. In 83 per cent. of the cases where there was no ulceration the stomach was sterile, while in only 28 per cent. of those with ulceration was it so. Dr. Hewetson has also, by experiments on himself and a number of gastrostomy patients, discovered the approximate time required by a healthy stomach to destroy certain classes of bacteria. He found that rich growths of staphylococcus pyogenes aureus were completely destroyed in from thirty to forty-five minutes after being swallowed, while bacillus pyocyaneus required about twice that time. Further, it is noted that no ill result ever followed the ingestion of virulent cultures of these organisms. The practical bearings of these observations are wide, both in the domains of medicine and surgery. On the one hand they show us of what importance it is in the prevention of intestinal infection that the gastric wall and its secretion should be in a healthy condition. Though, of course, it is impossible to perform experiments with the typhoid bacillus similar to those reported by Dr. Hewetson, there is no reason to believe that its resistance to gastric juice is greater than that of the organisms with which he has experimented. If we are right in this, it will tally with the current belief of clinical observers that a low state of vitality generally, and particularly a disorder of the gastric secreting function, is an important element in the causation of that disease. From the surgical point of view, the comparative sterility of the stomach and jejunum is of interest as showing how slight is the danger of sepsis in most cases of operation on these viscera, and as explaining the ease with which small wounds, such as bullet wounds, of the upper part of the alimentary canal heal. From bacterioscopic examination of the extravasated fluid in cases of perforation of the stomach, important practical results follow as regards prognosis. If the fluid should be, as often happens, sterile, an excellent prognosis may be given. On the other hand, though the presence of bacteria does not necessarily mean a bad outlook, yet the prospects are worse in proportion to the number and virulence of organisms present.

#### MEDICAL MEN AND POISONOUS DRUGS.

LAST week the City Coroner, Dr. F. J. Waldo, held an inquest which opens up many considerations of importance to the medical profession. The inquiry was held by him upon the body of a man whose death was alleged to have taken place from an overdose of opium prior to his removal for an operation at St. Bartholomew's Hospital. The facts of the case, briefly narrated, were as follow. For several weeks deceased had been ailing, when he became so much worse that his

(a) *Brit. Med. Journ.*, November 26th, 1904.



medical man called in a consultant. The latter diagnosed appendicitis and ordered opium externally and internally. A box of pills was sent with the directions that one pill was to be taken every four hours, instructions which were followed by the nurse subsequently engaged, although she stated that she had no knowledge of the nature of the medicine. She had then seen neither of the medical men in attendance, and when she left the case for purposes of rest she gave the patient's mother instructions in writing to continue the pills. The mother and three other witnesses swore that both boxes had written instructions upon them to the effect that two pills were to be given every half hour until sleep was induced. The medical attendant, on the other hand, swore that there were no written directions at all on the second box but that he had ordered two pills to be given at once, and one pill every two hours afterwards until sleep followed. The nurse's version of this was that he directed her verbally to give two pills at once and two more every half hour subsequently. The attention of the medical attendant was at length arrested by the state of the patient's eyes, and he himself admitted in evidence that he remarked that the sick man "had had too many pills." A surgeon was summoned who advised immediate operation, which was performed at St. Bartholomew's Hospital on the Saturday evening, but the patient died on the following evening. Under these circumstances it is hardly to be wondered that the relatives of deceased communicated with the Coroner. There can be little doubt that owing to some misunderstanding an unusual amount of opium was administered to the patient. According to the wife's statement, she gave her husband twenty or thirty pills between 11.30 a.m. and 4 p.m. on the Saturday. The surgeon stated that death resulted from shock and not from the effects of opium. A *post-mortem* examination revealed extensive organic disease, so much so that it was extremely improbable deceased could have survived any severe operation. That fact, however, does not shift the responsibility for the laxity shown in dealing with so dangerous a drug as opium. Clearly it would be inadvisable for medical men to label distinctively all medicines for internal use which happen to contain poison. At the same time ordinary prudence would suggest that in giving opium pills no more than a maximum day's dose should be entrusted to the patient's friends, and that clear and full written instructions should be appended. Had a chemist dispensed boxes of opium pills in the wholesale fashion that appears to have been done in this case, especially without proper directions, or with none at all, as the medical man asserted was the case with the second box, he would have laid himself open to a charge of manslaughter. Speaking generally of another aspect of the case the use of opium in latter days has considerably diminished, in fact, many modern practitioners would regard opium as a last resort in hopeless cases and would then order it only

with the merciful view of securing a state of euthanasia. The use of narcotics in appendicitis has been practically abandoned and there appears to be little question that its administration merely serves to mask symptoms and greatly to reduce the chances of success in any operative measures that may be afterwards undertaken. However, opium no doubt still has its value in skilful hands, and under special circumstances which were no doubt present in the case under notice. On the whole the medical attendant may consider himself somewhat fortunate that he has escaped more serious consequences than a rider from the jury, representing that in all cases where medical men prescribed poisons it was desirable that the package should bear instructions as to their administration but not necessarily the name of the drugs. Had this particular inquest been in the hands of a pathologist and a coroner whose relations with the medical profession were not of the most cordial nature, the results might have been of a less reserved and conciliatory character.

## Notes on Current Topics.

### Mr. Beck's Double.

AN interesting example of the ethics of irregular practice is supplied by the history of John Smith, the criminal who, in addition to his original misdemeanours, allowed another man to suffer the punishment that should justly have been his. John Smith who, after all, is not particularly like the unfortunate Mr. Beck in appearance, has passed a wandering, adventurous life, living apparently for the most part "on his wits," and in certain stages of it not doing so badly. He is said to be a man of extraordinary ability and intelligence, who can speak and write no fewer than thirteen languages and was at one time the moving spirit of all gatherings and social functions in Adelaide. He has been in many countries and is possessed of a large amount of general information about people and things, not the least interesting of his experiences being those gained in the Hawaiian Islands as assistant to Father Damien in ministering to the lepers. But the part of his career which will have most interest to medical men is that spent in Australia, where he set himself forth as a specialist in the treatment of tuberculosis and skin diseases. Where he gained his knowledge is somewhat of a mystery, but when he was challenged as to his right to practice, diplomas of high merit were forthcoming to substantiate his claims. To whom these diplomas were originally granted is not known, but Smith made a great reputation on the strength of reputed medical knowledge and skill, and gained a large and lucrative practice; so much so that the general practitioners of Adelaide found his opposition cut seriously into their incomes. His practice is said to have been the largest in the town, and even legally-qualified practitioners seem to have availed themselves of his help from time to

time. Why he gave up a comfortable livelihood is not mentioned, but probably the routine of medical work preyed on his versatile nerves, and he set off on some more exciting pursuit. The moral of the tale is so obvious that one need not dwell on it; the spirit of the irregular practitioner is essentially that of the adventurer, and from quackery to crime is but a short step.

#### Alcoholic Automatism.

It is not an uncommon occurrence that certain acts are committed by a drunken person of which, when sober, he is quite oblivious. Indeed, after a violent fit of intoxication, more often than not the subject forgets a great part of what happened while he was in that state. Of entirely different order, however, and deserving of close study, are those cases of temporary loss of consciousness which sometimes occur in habitual alcoholics. It happens that a patient in this condition may commit some offence against the law, for which he is afterwards brought to book, although he protests, quite truly, entire ignorance both of the alleged crime and of his own movements at the time. Dr. Crothers, the distinguished American alienist, deserves credit for drawing the attention of medical men to this condition, which indeed is often unrecognised. It usually occurs in persons who are in the habit of consuming fair quantities of spirits, without at any time actually becoming drunk. Suddenly, and for a period varying from some hours to several days or even weeks, the patient passes into a condition of unconscious automatism, exactly resembling that which may occur in epileptics following a fit. On recovery from the condition his mind is an entire blank as to what has taken place during the interval. His actions may have been perfectly regular and usual, attracting no attention from those he has met. On the other hand, he may, apparently in a sober and rational manner, have performed some strange act, such as murder, wrecking a train, or disposing of his property without cause. Without going into the vexed question of the degree of criminal responsibility in alcoholics, it is obvious that it is the duty of physicians, as well from a scientific as from a medico-legal point of view, to study carefully any cases of alleged amnesia which occur in alcoholic subjects.

#### Osteopathy in England.

THE "science" of osteopathy is largely cultivated in America; it has its colleges, its professors, its diplomas, and its *clientele* of laymen, who prefer the ministrations of the osteopathic doctor in times of sickness to those of the legitimate practitioner. Not the least use to which the Americans put their boasted freedom is that of choosing what "system" their ailments shall be treated by, and as their proverbial "cuteness" is allied with a generous share of credulity the quack of all species has an excellent field for his enterprises. The osteopathist is quite a recognised institution in many States, and Bills have been introduced into their legislatures to legalise his position as a

practitioner. Fortunately these Bills have all been defeated, and, more fortunately still, the osteopathist has not hitherto ventured to cross the Atlantic. But whether it be from the local over-production of osteopathists or from the science developing cosmopolitan tendencies, this country is at present to have at least one professor dumped into its midst. His arrival has been heralded in the columns of one of the small fry of "society" journals who keep up their circulation by providing mild sensations for their readers. This particular publication is somewhat partial to novelties in the medical line, so that the osteopathist is quite a little god-send to it. Some time back its columns were descanting on the skill of an appendicitis-curer who was able to accomplish by electricity all that surgeons could or could not do for that disease by the knife. This professor seems to have disappeared, for we have not heard of him lately, but his place is more than supplied by the osteopathist who can remove stoppages in the blood, "merely in a moment," and by replacing bones and untwisting muscles is able to perform "some instantaneous cures." We only regret that there is no instantaneous cure for those who are beguiled by such nonsense.

#### Abolition of Sea Burial.

A PROPOSITION of a curious sort is being mooted at present in New York. It is that a law should be passed forbidding the burial of any dead body at sea. We confess, on first reading the suggestion, we were in some doubt as to how it could have originated, but the matter afterwards became clearer. The custom itself is an eminently sanitary one, and it seemed hard to find any arguments against it. On the other hand, the retention of a body till land could be reached is open to grave objection. In but few vessels would there be any sufficient method of preservation available, and the keeping a dead and decomposing body for weeks on a tropical voyage would be no less offensive than dangerous. Indeed, in many cases it would be an impossibility, and in all an inconvenience. The explanation of the suggestion, however, is simple. It originated in an address given by the President of the New York State Embalmers' Association! We shall hear next probably of gravediggers demanding a law to put a stop to cremation.

#### The Antiseptic Barber.

DR. COLLINGRIDGE'S recommendations for safeguarding the City populace from infection conveyed at hairdressing establishments have been approved by the Court of Common Council, and have now been published. They are certainly thorough, and if carried out by the barbers with the same zeal as that with which they were conceived by Dr. Collingridge, a "shave and hair-cut" in the heart of the Empire should have no terrors, even to the most timorous. The regulations demand that all shelves and fittings in hairdressers' shops small be made of glass, marble, or other impervious material; that clean towels be used and fresh

paper or linen placed on the head rest of the chair for each customer; no sponges or powder puffs be used; all shaving-brushes, combs, scissors, razors, &c., be placed in disinfectant solution after use; no general alum-blocks be used as a styptic; and various other drastic measures for ensuring cleanliness be instituted. Hairdressers complying with these demands will be registered and certificated as fit and proper persons to undertake the removal of superfluous hair from their clients. We should be inclined to regard the scheme as Utopian were it not for the fact that the regulations were drawn up and approved by a joint committee of the Public Health Committee of the Council and of the Incorporated Guild of Hairdressers, and it may be taken as certain that the latter would not have sanctioned any measures that could not be carried out in consonance with business principles. There are, however, many small barbers' shops at which the penny and three-halfpenny shave is a great attraction, and we confess ourselves unable to see how such establishments are to carry on their trade at a profit unless their prices are raised materially. At any rate, the ideal of what a barber's establishment should be and how it should be managed will be lifted to a higher plane by the action of the Common Council, and we trust their excellent example will have an influence extending far beyond the square mile over which they rule.

#### Surgery in the Newspapers.

OUR readers are aware that some of the less reputable of the London daily papers have been in the habit during the past year or two of publishing paragraphs dealing in a sensational manner with surgical affairs. The articles are usually ill-informed, and almost invariably give the public a false impression of the matters dealt with. In addition they not infrequently give an unseemly prominence to the name either of some hospital, or still worse, of some surgeon. We regret that this custom, which we had hoped was confined to the London press, is spreading to other places, and within the past week two respectable Dublin newspapers published paragraphs of this kind. In one case a highly-coloured and absurdly inaccurate account was printed of the operation for excision of the Gasserian ganglion which had been done a day or two before in one of the Dublin hospitals, the name of the latter being given. Among other things it was stated that this was only the fourth time the operation had been performed. In the other case a long account was published of an operation on the stomach for the removal of foreign bodies. It is greatly to be regretted that respectable journals lend themselves to the purveyance of sensational news of this sort.

#### A Consumption Cure.

AN amusing action was tried before Mr. Justice Lawrence last week in which a Mrs. Long sued Dr. Boyd for breach of contract in connection with the discovery of a treatment for consumption which Mrs. Long was trying to introduce to the notice

of the world. The remedy in question is a blending of herbs which is described as an "absolute cure," and a good deal of fun was created in the course of the trial by one of the witnesses relating that her husband had died of consumption after taking this absolute cure. The plaintiff conducted her own case, and the evidence produced in support of it was so slight that the jury returned a verdict for Dr. Boyd without leaving the box. Indeed, no other result was possible, and so ridiculous were the proceedings that Dr. Boyd is more to be condoled with on the annoyance and expense to which he was subjected than congratulated on a result which was inevitable from the beginning. One of Mrs. Long's witnesses was Sir William Broadbent, who confessed that he had no idea why he had been subpoenaed, and whose evidence consisted principally in shaking his head when asked several times if he would not try her remedy on hospital patients. The Judge excused him from attendance as soon as possible, and the farcical action continued. A man named Smith who had been given up as an incurable consumptive gave evidence that he had been cured by Mrs. Long, and that his case was a most complicated one. Dr. Watson, who was called by Dr. Boyd, was able to prove that the complications from which Smith suffered did not include consumption, and altogether Mrs. Long's patients did not provide very good advertisement for the absolute cure. The ground for the action was professedly that Dr. Boyd had availed himself in confidence of the precious secret and exploited it for his own profit—an insinuation one would have thought that hardly needed rebutting. It is a curious thing that the time of the courts can be wasted, and professional men put to inconvenience and expense, for silly actions of this kind; the only function they serve is to entertain the readers of evening papers. The doctor as a rule has to make sufficient appearances in court as a witness without being summoned in frivolous action, which are of no use to anybody except the lawyers.

#### The Treatment of Bad Temper.

WE do not remember in any work on therapeutics to have seen a chapter devoted to the treatment of irritable temper. Nor, indeed, is irritable temper as such commonly brought under the notice of the physician for medical treatment. Many physicians must, nevertheless, number among their patients certain irascible individuals the reduction of whose temper to an equable frame would be a blessing not only to themselves but to their associates in business or family life. For the treatment of such people a hint may be gathered from the communication which Sir Lauder Brunton has been persuaded to make to a lay journal. Our contemporary sought advice from several clerical gentlemen as to the best method of preserving perpetual amiability, and, reflecting that the body as well as the soul might be concerned, invited also Sir Lauder Brunton's opinion. He, by his own confession, is in the habit of prescribing what he

calls a "temper-powder," with excellent effect in cases of irritability in gout. It consists of 20 grains of bicarbonate of potash, with 10 to 20 grains of bromide of potash. In cases where the irritability springs from cardiac disease or "is the precursor of headache," "a few doses of bromide of potassium and salicylate of soda give relief and improve the temper." We have no doubt that Sir Lauder Brunton's prescriptions are admirably adapted to their purpose, but we hardly think the columns of *The House Beautiful* a suitable channel for their publication.

#### Dangers of Celluloid Combs.

THE risks attending the use of celluloid combs and collars have been abundantly illustrated by many a tragedy. Again and again have the luckless wearers of such articles been severely or fatally burnt by chance contact with a flame. There is another celluloid danger, however, to which the public is not generally alive, namely, the use of that material so cleverly masked as to be unrecognisable as celluloid save to the expert in such matters. The facts of a recent case brought under our editorial notice were as follows:—A young lady in the country was wearing two handsome and costly combs, apparently made of tortoiseshell, mounted with silver and ornamental stones, while tending a sick domestic pet—country-wise—in the kitchen. She stooped with her head some two or three feet away from a hot fire for a space of about ten minutes or a quarter of an hour. Suddenly her head was seen to be enveloped in smoke. The smouldering material, which proved to be the so-called tortoiseshell, burnt through aprons and other extinguishers, and was at last subdued only by a prolonged douche beneath the kitchen water-tap. The resulting burns were severe and, had not prompt assistance been at hand, might readily have proved fatal. The moral of all this is that the world of women should learn that combs may be sold to them at high prices as tortoiseshell, whereas they are in reality made of inflammable celluloid. The aristocratic tortoiseshell does not blaze and smoulder, and when placed in an actual flame departs from the world in the odour of calm and stoical incineration. Vulgar celluloid, on the other hand, swells up into an inflated mass of hot and vixenish combustion when brought close to a stove, lamp, or other source of heat. Therefore, ladies, be sure what you buy as tortoiseshell is the real thing and not that modified form of gun-cotton known as celluloid.

#### A Judge's "Surprise" at a Medical Witness.

THE easy-going ways of the medical profession are, beyond a doubt, answerable for the loss of a good deal of legitimate income. Take, for instance, the lax methods of medical men compared with those of lawyers engaged in a legal case. Before coming into Court the lawyer either pockets his fee, or assures himself with a reasonable amount of certainty that his costs will be forthcoming should his client win or lose. Woe to the medical witness who is weak enough to give evidence

without a clear undertaking as to payment of fees. Even where his evidence is material to a decision he runs a considerable chance of receiving never a penny in return for his services. That kind of experience comes sooner or later to the young medical man and burns into his soul the conviction of the folly of trusting either lawyers or litigants when it comes to a question of payment of witness' fees. The proper course is for the medical man, when he steps into the witness-box, to refuse to be sworn unless his fees are first paid. It is astonishing how often judges are apt to bring pressure to bear upon medical men under such circumstances, although their zeal for gratuitous justice rarely, if ever, extends to members of the legal profession. Some weeks ago Judge Gwilym Williams, in a compensation case brought against the Great Western Railway, adopted an extreme, and, so far as can be gathered from a report in the *Western Mail*, an unfair attitude towards a medical man in Court who had been subpoenaed by both sides, and who naturally wanted to know who was going to pay for his evidence. The judge is reported to have said severely: "I am surprised at a medical gentleman making so much fuss about his fees in a case of this kind when so much is at stake." Surely, if the magnitude of the case is to be an argument against ensuring the payment of fees, the rule would apply equally to the judge, counsel, solicitors and unskilled witnesses. Subsequently the judge expressed regret for those remarks on the ground that Dr. Evans' evidence was of the utmost importance, but we fail absolutely to recognise the proposition that the rights of a witness are to be upheld or treated with contempt in proportion to their direct value in relation to the merits of a given case.

#### Sanatoria as Public Educators.

THE anti-tuberculosis crusade, however much its achievements may fall short of its aims, is exercising an influence of untold weight in the education of our countrymen in the matter of phthisis and its prevention. Every local committee in this way becomes a radiant centre for the diffusion of knowledge of the highest preventive value in its immediate neighbourhood. A good instance of the awakening effect of the crusade was shown last week in the important inquiry opened at Exeter by the General Purposes Committee of the Devon County Council as to the proposed establishment of a hospital for the treatment of phthisis. The widespread public interest in the question was evidenced by petitions from five towns and a large number of public authorities concerned. Of the latter no less than thirty-two bodies expressed themselves in favour of the proposed hospital. In addition, many prominent men, medical and non-medical, expressed views which will gain the widest publicity by means of newspapers and reports. In this case the Exeter organisation has spread the leaven of useful information not only through Devon, but also through adjoining counties.

### The Late Sir William Mitchell Banks.

ON Tuesday, November 29th, a meeting was convened at the Liverpool Town Hall, under the presidency of the Lord Mayor, to take into consideration a proposal to perpetuate in some fitting and material way the memory of the late Sir William Banks, M.D., F.R.C.S. The meeting was in every way a representative and influential one, and a spirit of unanimity pervaded the whole proceedings. It was everywhere felt that the late distinguished surgeon had deserved well of the community amongst which he had spent a laborious and eminently useful life. It was, and is, felt by many that the Liverpool University itself owes its very existence to him; more so, perhaps, than to any one individual besides. The Lord Mayor proposed: "That a memorial of a permanent character be established to commemorate the name and the services of the late Sir William Mitchell Banks." The proposition was seconded in an eloquent speech by Vice-Chancellor Dale, who observed that a "better idea had occurred to some influential friends of the movement that there should be a lectureship established, permanently identified with Sir William Banks' name and associated with the objects of medical education which he had in view." The idea seemed to "catch on" at the meeting, and at the close a subscription-list was opened, when a considerable number of the gentlemen present liberally responded. There can be no doubt that the movement will be carried to a deservedly successful issue.

### The Pastime of Cycling.

FROM the point of view of the medical man, cycling as a form of physical exercise cannot be too highly recommended, but naturally everything depends upon the way in which it is followed. The method, of course, of the "Clan McScorcher"—the members of which pace the roads at the topmost of their powers, with their noses on the handle bar, and their backs and arms curved like "monkeys on the stick"—need only be mentioned to be condemned; often the youths who thus attempt to acquire the name of "speed merchants," as the term goes, may be met with whose faces, from their cyanosed condition, betoken only too plainly the dangerous physical effort to which they are subjecting themselves. Again, cycle racing is a prostitution of this pleasure-affording, attractive pastime which calls for no further comment, even apart from the direct risk to life to which its followers are exposed. In view, then, of the health, enjoyment, and exercise which pleasure cycling affords, it is regrettable to note that evidence exists of its waning popularity. We presume that the Cyclists' Touring Club may be taken as representing the measure of popular interest devoted to cycling in this country, and yet while a few years ago the membership of this club amounted to nearly 60,000, in the present day it has diminished to half that number. What does this mean? Does it imply that cycling is less attractive as a pastime than it used to be? We sincerely trust that this is not the case; on the other hand, it seems difficult

to account for the serious falling off in the membership of this erstwhile flourishing club. The latter, however, recently announced that they were about to embark upon a new scheme in which they had great hopes of bringing back the popularity which they had lost. This great scheme consists in offering to spend some of the club's hard-earned savings to the extent of £400 in prizes for the discovery of a device for preventing side-slip. We may now expect the railway companies to offer prizes for the prevention of railway accidents. The idea of such a scheme is splendid from the point of view of its impracticability, and it is scarcely needful to state that if the Council of the C.T.C. can suggest nothing better than this to restore the former popularity of the club, the members should take an early occasion to elect other representatives to protect their interests.

### The "Hospital" and the Funds.

THE Editor of the *Hospital* is exceedingly wroth with THE MEDICAL PRESS AND CIRCULAR for not having replied forthwith to his challenge to us to substantiate certain statements with regard to the Hospital Sunday and King Edward's Hospital Funds. He may rest assured that there will be plenty of material for him to work upon before the Ides of March are upon us. Pressure upon space and the verification of facts and figures, so far as possible upon the basis of scanty reports, may or may not be accepted as satisfactory reasons for the delay, but in any case we have not the least intention of being hustled by the editor of any contemporary, lay or medical. The relations of the Royal Orthopaedic Hospital to the Hospital Sunday Fund will require restating, as the Editor of the *Hospital* has failed to grasp our points. We fear our contemporary will have to wait another week, but we note that delay does not prevent him anticipating some of our arguments.

### PERSONAL.

DR. PRIESTLEY SMITH, who has filled the post of Ophthalmic Surgeon to the Queen's Hospital, Birmingham, for more than thirty years, has resigned his appointment. The Committee have accepted the same "with deep regret," and, as a mark of their appreciation of his services, have recommended the Governors that he should be elected honorary consulting surgeon to the hospital.

THE lifework of the late Sir Wm. Mitchell Banks, Emeritus Professor of Anatomy at the Liverpool University and Consulting Surgeon to the Royal Infirmary, is about to be perpetuated by a memorial, the form of which is undecided. We refer more fully to the subject in the previous column.

By a recent decree of the Provost and Senior Fellows of Trinity College, Dublin, a Chair of Applied Chemistry has been established in the University. The first occupant is Mr. E. A. Werner, for many years Assistant to the Professor of Chemistry. His work is well known in the scientific world.

PROF. SIR W. JAPP SINCLAIR, M.A., M.D., has been

lected Chairman of the Universities of Glasgow and Aberdeen Conservative and Liberal Unionist Association for promoting the candidature of Prof. William R. Smith, M.D., to represent these Universities in Parliament.

THE Nobel prize in the Physical and Chemical Sciences Section is, according to the Paris *Journal des Sciences*, likely to be awarded this year to Sir William Ramsay, Professor of Practical Chemistry in University College, London.

AN appeal, signed by the Hon. Sydney Holland, Sir Francis Laking, Sir Frederick Treves, and Mr. Malcolm Morris, has been issued for subscriptions to the fund for the erection of a monument to the late Professor Finsen. The British Committee formed to co-operate with the Danish Committee has received a donation of £50 from the King and of £100 from the Queen. Subscriptions may be paid to the Finsen memorial fund at the National Provincial Bank, 112, Bishopsgate Street, London, E.C.

THE Earl of Rosebery, Chancellor of the University, has given £1,000 to the Institute of Medical Sciences Fund, University of London.

THE Astley Cooper Prize of £300, which is offered triennially for medical research, has been awarded to Mr. W. Sampson Handley, Hunterian Professor in the Royal College of Surgeons, for an essay entitled "Epigastric Invasion of the Abdomen in Breast Cancer."

MR. LYNN THOMAS, C.B., F.R.C.S., has accepted the position of honorary consulting surgeon to Barry Hospital.

DR. DONALD MACALISTER, of St. John's College, Cambridge, has been elected President of the General Medical Council, on the retirement of Sir William Turner.

LADY CHEYLESMORE, wife of the Mayor of Westminster, opened the new building of the Royal Ear Hospital, recently erected at 42 and 43, Dean Street, Soho, on Monday last, at 3 p.m.

WE are officially informed that the Local Government Board of Scotland have appointed Dr. Fred. Dittmar, M.A., M.D., D.P.H., to the office of Medical Inspector, vacant by the promotion of Dr. W. Leslie Mackenzie to be Medical Member of the Board. He is the Medical Officer of Health for Scarborough, and previous to his present appointment he was for some years resident Medical Officer to the City of Glasgow Fever Hospitals, and afterwards assistant to the Medical Officer of Health for that city.

MR. JOHN UTTING, J.P., a medical member of the city council, has been elected to the important post of Chairman of the Port Sanitary and Hospitals Committee of the Liverpool Corporation.

ON November 22nd, the Right Hon. George Wyndham, M.P., Chief Secretary for Ireland, was formally installed as Rector of the University of Glasgow. The Corporation of the city was represented by the Lord Provost, Sir John Ure Primrose, and several members of the town council.

DR. RECLUS, Professor of Operative Surgery in the Paris Faculty of Medicine, has been appointed at his own request Professor of Clinical Surgery in succession to the late lamented Professor Tillaux.

THE following telegram from Sir C. Boyle, Governor of Mauritius, has been received at the Colonial Office:—"For the week ending December 1st, 32 cases of plague, 25 fatal, 2 white."

## Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

### SCOTLAND.

GLASGOW MATERNITY HOSPITAL.—H.R.H. the Princess Louise, whose philanthropic interest in medical charities has been conspicuous on many occasions, attended a meeting in the Grand Hotel, Glasgow, on November 29th, for support of the movement for the extension of the Glasgow Maternity Hospital. For a number of years the work of the hospital has been hindered by lack of accommodation, both for patients and students, and to remedy this the directors have acquired a considerable amount of property adjacent to the present building, on which, in addition to increased accommodation for patients, they intend to provide a school for the practical teaching of midwifery and gynæcology. The sum required to be collected is £54,500, including £14,500 as the cost of the site and £40,000 for new buildings. Professor Murdoch Cameron, after dwelling for a moment or two on the poverty of many of the inhabitants of a great city like Glasgow, in which 30 per cent. of the houses were of one apartment only, said that during the past ten years the hospital had attended 29,013 cases, 90 per cent. of which had been the wives of poor working men. During the same time they had trained 1,244 students and 800 nurses. These men were now practising throughout the country, and those who had comfortable homes were at the mercy of these men and women therein trained and educated for their work. His Grace the Duke of Argyll moved the following resolution:—"That in view of the urgent need that exists for the increased accommodation of patients, and for the training of students and nurses, this meeting resolves to support the Directors of the Maternity Hospital in their efforts to effect both these objects." This was seconded by Prof. A. R. Simpson, Edinburgh, and carried. Lady Ure Primrose moved the second resolution:—"That the meeting do all in its power to raise the necessary funds," which was supported by Rev. Dr. Macleod, and carried.

SCHOOL BOARD CERTIFICATES.—The Dundee Branch of the British Medical Association has passed a resolution maintaining that the responsibility for the supply of medical certificates for absent children rests on the School Board, and recommending medical officers of charities and other public bodies to decline to fill them up. This entirely reasonable action appears to have incensed the School Board authorities, for one of the members in consequence asserted that the medical profession were desirous of foisting two or three of their own number on the Board. He pointed out, what is, we think, sufficiently well known, that until a new Act was in force the School Board had no power to appoint medical men, but this in no way makes the present system of expecting every medical officer to a charity to fill up certificates for non-attendance at school less anomalous.

### BELFAST.

ANNUAL DINNER OF THE ULSTER MEDICAL SOCIETY.—The annual dinner of the Ulster Medical Society was held on Saturday evening last in the Medical Institute, Belfast, when a marble bust of Sir William Whitt, the donor of the Institute, was unveiled by Sir Lauder Brunton, who had kindly come from London for the purpose. The chair was occupied by the President of the Society, Dr. William Calwell, and among the guests present were the Lord Mayor of Belfast, the President of Queen's College, Belfast, Mr. Chance, the President of the Royal College of Surgeons, Ireland; Professor W. Smith, T.C.D.; Sir John Moore, Sir Wm. Thompson, Sir T. Myles, and Professor Lorrain Smith. After the toasts of the "King" and the "Lord Lieutenant" and "Prosperity" to Ireland, Dr. Calwell called on Sir Lauder Brunton, explaining in a few words the history of the Institute and of the movement to provide a permanent memorial of the donor in it. Sir Lauder Brunton, who received a very enthusiastic welcome, spoke of his many years' friendship with Sir William



Whitla and of the personal qualities of kindness and sympathy which endeared him to all with whom he came in contact, of his success as a practitioner and teacher, and, lastly, as a writer who had enriched the whole world by his works. The Ulster Medical Society were under a special debt of gratitude for the Institute; he attached the greatest importance to the opportunities for social intercourse which it afforded and encouraged, for differences of opinion and divided interests were sure to arise in the course of practice which could be smoothed down by the men meeting together in friendly social intercourse. He had the greatest pleasure in unveiling the bust and proposing the health of the donor of the Institute. Sir William Whitla was also received very warmly on rising to reply to his health. He thanked Sir Lauder Brunton from the bottom of his heart for all his kind and flattering words, and said that for all he had done he was amply repaid when he looked into the Institute occasionally in the evening and saw the members of the Society enjoying its use. He gave an amusing account of the modelling of the bust in clay by Miss Kathleen Shaw, the sculptor, and his hope, when he found that the clay had been previously used for a bust of the Primate of All Ireland, that some of his great gifts of oratory might descend on him, but when he tried to express his feelings he found he was common clay after all. The other toasts were "The Dublin Schools of Medicine," proposed by Professor Lindsay, and responded to by Mr. Chance, President R.C.S.I.; Professor Walter Smith, T.C.D., and Sir John Moore, Ex-President R.C.P.I.; "Our Guests," proposed by Dr. Walton Browne and responded to by Sir Lauder Brunton and the President of Queen's College; and "The President," proposed by Dr. Kevin, responded to by Dr. Calwell.

**THE HEALTH OF THE CITY.**—During the four weeks ending November 10th, 276 cases of zymotic disease were notified in Belfast, including 63 typhoid, 70 simple continued fever, 56 scarlet fever, 41 erysipelas, 18 small-pox, 21 diphtheria, 5 membranous croup, and 2 puerperal fever. The deaths from zymotic diseases were 72, and those from phthisis and other diseases of the respiratory system 189. The annual death-rate from all causes was 18.4, an increase of 0.5 over the same period last year.

**THE SMALL-POX OUTBREAK.**—During the past fortnight there have been 10 new cases of small-pox discovered and removed to hospital. Four of these were from one family; two children had suffered from mild attacks and were only found out when another child, unvaccinated, took a severe attack, and the father also became ill. Two other cases of the ten were unvaccinated, an adult and a child of fifteen months. Except for these unvaccinated cases, the general type of the disease is mild. There was one death during the fortnight, an unvaccinated adult of 37, who had come in the previous week. The outbreak has now lasted nearly fourteen months, and there have been 137 undoubted cases of small-pox under treatment.

## Special Reports.

### THE GENERAL MEDICAL COUNCIL.

SATURDAY, NOVEMBER 26TH.

The President, SIR W. TURNER, in the Chair.  
Aosent, Mr. Morris, Mr. Power, Mr. Tichborne.

The Minutes of the last meeting were read and confirmed.

Dr. CATON was elected on the Examination Committee as a member representing the English Branch Council, in the place of Dr. Payne, no longer a member of the Council.

Moved by Sir PATRICK HERON WATSON, seconded by Dr. McVAIL, that the Report of the Examination Committee on the Inspection of the Final Examination of the University of Edinburgh be received and entered on the Minutes.

The Committee in their Report (signed by the Chairman, Sir Patrick Heron Watson) recommended that

As the difference of opinion between the Visitor and Inspector on one hand, and the University on the other, is fundamental as to the nature of the Surgical Examination, and as the Visitor and Inspector have not given any detailed evidence in support of their adverse criticisms, and as some of the Statements of Opinion by the Visitor and Inspector are irreconcilable with each other, the Medical Council should direct that a further inspection be made of the surgical part of the Final Examination in the University of Edinburgh.

Sir JOHN TUKE proposed, and Dr. MACKAY seconded, an amendment to omit certain phrases in the Section of Remarks by the Visitor and Inspector before the Report was entered on the Minutes.

A long discussion followed, nearly all the speakers being of opinion that all Reports of Visitors and Inspectors should be treated with great respect, and should be sent on entire to the Privy Council.

Sir JOHN BATTY TUKE and his seconder sought the permission of the Council to withdraw his amendment in favour of another by Dr. Norman Moore.

Dr. PYE-SMITH moved the closure, and that the Council should proceed to vote on the amendment. Dr. LINDSAY STEVEN seconded, and the motion was carried.

The Council then proceeded to vote on the amendment, which was lost 22—4; 4 did not vote, 3 absent.

It was then put that the Report be received and entered on the Minutes. This was carried.

Moved by Dr. NORMAN MOORE, seconded by Sir VICTOR HORSLEY, and carried: "That the discussion on this Report be adjourned to Monday, November 28th, 1904."

Dr. WINDLE moved that the Report of the Education Committee be received and entered on the Minutes. He clearly explained the scheme it contained. Sir CHRISTOPHER NIXON seconded.

Moved by Dr. WINDLE, seconded by Sir CHRISTOPHER NIXON: "That any well-considered plan which would tend to a diminution in the number of examinations in preliminary subjects of education, and to a unification of standard of those which remain, would meet with the hearty approval of the Council."

Sir VICTOR HORSLEY proposed, and Mr. JACKSON seconded, an amendment: "That while recognising the practical difficulties of unifying methods of testing secondary education, the General Medical Council expresses the hope that the Board of Education may, in considering any system of School Certificates, find it possible to establish a Central Board for the purpose of creating and supervising a single examination of such a standard that it might, in the opinion of the General Medical Council, be recognised as qualifying for entrance to a course of professional study."

This was lost, 18—4; 8 did not vote, 3 absent.

Dr. Windle's original motion was carried.

Moved by Dr. WINDLE, seconded by Dr. PYE-SMITH, and agreed to: "That if the Standard of Examination contemplated in the scheme were such as to be generally accepted for entrance or matriculation by the Universities of England, the Medical Council would be prepared to recognise it as qualifying for entrance on a course of professional study."

Moved by Dr. WINDLE, seconded by Dr. MACALISTER, and agreed to: "That pending the general adoption of a uniform system of educational tests, the Council would welcome the establishment under the Board of Education of a Central Board, for the purpose of classifying examinations according to standard and arranging for the mutual recognition of certificates; and, further, that they regard the establishment of such a Board as highly desirable from an educational point of view."

Moved by Dr. WINDLE, seconded by Sir JOHN MOORE: "That the Report of the Education Committee as modified be approved."

The Reports of the Pharmacopoeia Committee and of the Finance Committee were received and entered on the Minutes without discussion.

The Council then adjourned.

MONDAY, NOVEMBER 28TH, 1904.

The President, Sir WM. TURNER, in the Chair.  
Absent, Mr. Morris, Mr. Power, Mr. Tichborne.

The Minutes of the last meeting were read, amended, and confirmed.

The Council proceeded to the consideration, adjourned from November 26th, 1904, on the motion of Dr. NORMAN MOORE, seconded by Sir VICTOR HORSLEY, of the Report by the Examination Committee on the Inspection of the Final Examination of the University of Edinburgh. The inspection contained an unfavourable criticism on some of the arrangements and methods of the Examination in Clinical Surgery. The Visitor and Inspector also deemed it their duty to point out the desirability, if not the necessity, of the Edinburgh University, with all other teaching bodies, so adjusting its curriculum as to give Medical Students greater facilities than they now seem to possess of gaining a better knowledge of disease and its treatment by clinical work.

Moved by Sir PATRICK HERON WATSON, seconded by Dr. McVAIL: That the Recommendation of the Examination Committee contained in the Report be adopted.

The PRESIDENT, as representing the University of Edinburgh on the Council, made a few remarks in defence of the system of Examination in Clinical Surgery therein. He thought some parts of the Report by the Visitor and Inspector might be regarded as strongly adverse criticism, and some of the statements as of a very sweeping character. He pointed out that the difference among schools in the Examination in Surgery on the cadaver was mainly due to some schools getting more bodies than others, but that every candidate going through the University of Edinburgh must study Operative Surgery.

Sir VICTOR HORSLEY supported the Report and the Recommendations, as the rejections in Surgery at the University of Edinburgh were higher by a half than those in medicine.

An amendment was then proposed by Dr. PYE-SMITH and seconded by Sir JOHN MOORE: That the Recommendation be adopted in the following form: "That the Council direct that a further inspection be made of the Surgical part of the Final Examination in the University of Edinburgh during the year 1905."

Sir CHRISTOPHER NIXON considered that the Council should deal very tenderly with a Report of the Council's own Visitor and Inspector.

Professor Thomson, Dr. McVail, Mr. Brown, and Dr. Lindsay Steven made a few remarks, and Sir G. H. Philipson, as the Visitor in question, said a few well-chosen words in defence of the Recommendations; after which Sir PATRICK HERON WATSON and his Seconder accepted the amendment on the part of the Committee, and the Amendment, which had thus become the sole Motion, was put and carried.

Moved by Sir PATRICK HERON WATSON, seconded by Dr. McVAIL, and agreed to: "That the Report by the Examination Committee on the Inspection of the Final Examination of the Apothecaries' Hall, Dublin (July, 1904), be received and entered on the Minutes." The Report was then adopted. (Same Proposer and Seconder.)

Moved by Sir PATRICK HERON WATSON, seconded by Dr. McVAIL, and carried: "That the Report of the Examination Committee on the Inspection of the Final Examination of the University of Glasgow be received and entered on the Minutes." The Report was then adopted. (Same Proposer and Seconder.)

Moved by Sir P. HERON WATSON, seconded by Dr. McVAIL, and agreed to: "That the Report of the Examination Committee on the Inspection of the Final Examination of the University of Aberdeen be received and entered on the Minutes."

Moved by Sir P. HERON WATSON, seconded by Dr. McVAIL, and agreed to: "That the Report of the Examination Committee on the Inspection of the Final Examination of the University of St. Andrews be received and entered on the Minutes." The Report by the Visitor and Inspector was not always favourable, it

being mentioned, *inter alia*, that it was by no means certain that the method of excluding all the candidates from the wards of the Royal Infirmary for ten days previous to the examination was effective; also that in the oral examination in some cases only one examinee was present; also that the teaching examiner was too prone to show his teaching capacity rather than his examining power. On the other hand, great praise was given to the Examinations in Ophthalmology, in diseases of the ear, throat and nose, and in skin diseases. On the motion for the adoption of the Report being made by the same Proposer and Seconder, Dr. MACKAY, made a few observations in defence of St. Andrews, which were, however, rather traversed by Sir JOHN MOORE, the Visitor, who asked leave, which was accorded, to alter an error in a sentence of the Report, which now reads: "Both Examiners gave fifteen minutes each to the Examination of each of the six candidates." Subject to this correction the Report was adopted.

The Council then adjourned.

TUESDAY, NOVEMBER 29TH, 1904.

Sir WILLIAM TURNER, President, in the Chair.

The Minutes of the last meeting were read and confirmed after an explanation by Sir Hugh Beevor with reference to his signature appearing at the end of the report of the Visitation of the University of Glasgow; he had found out that his signature had been put in the final proof as a matter of form in the office, and the final proof had not been sent to him. He hoped that in future no signatures would be appended without a final proof being submitted.

Sir PATRICK HERON WATSON moved, Dr. McVAIL seconded, and it was agreed to:—"That the Examination Committee be requested to consider their Report on the Final Examination of the University of Edinburgh in conjunction with the results of the additional inspection of the surgical parts thereof directed by the Council to be made in 1905, and to present a Final Report of the second inspection at the November session of the Council in 1905."

Moved by Sir P. HERON WATSON, seconded by Dr. McVAIL, and carried: "That the Report by the Examination Committee on the further reply by the Royal College of Surgeons of England to the Inspector's report on the final examinations of the English Conjoint Board be received and entered on the minutes." The Examination Committee in their Report were satisfied with the alteration in the system of marking recommended by the Court of Examiners, but regretted that the Court of Examiners consider as unnecessary an examination in ophthalmic surgery, which the Committee regarded as being essential, and the Examination Committee did not see any reasons to alter their opinion that a written report on a medical or surgical case was neither useful nor practicable.

The adoption of the Report (same Proposer and seconder) was agreed to, after Sir CHARLES BALL had made a few remarks on the importance nowadays of a training in operative surgery, which he maintained could not be properly taught excepting on the dead body. Sir VICTOR HORSLEY received an affirmative answer from the President as to whether this question could not be taken up next session as a resolution based on this Report.

The Council next proceeded to the consideration (adjourned from Nov. 25th, 1904, on the motion of Sir BATTY TUKE) of the recommendations contained in the last paragraph of the report of the Public Health Committee: "That the Council should refuse a certain application for exemption."

Sir BATTY TUKE, in support of the refusal, thought that the introduction of individual cases was very dangerous, but he wished to withdraw his motion and refer the matter to the Public Health Committee next session.

Dr. LINDSAY STEVEN then moved, and Sir CHARLES BALL seconded, a modified amendment (of which notice had been given): "That should the applicant be admitted to the examination by any of the qualify-

ing bodies without having personally complied with Rule 3, the Council will have no objection to the registration of his diploma when obtained."

Dr. BRUCE, as chairman of the Committee, accepted the amendment, and in answer to Sir VICTOR HORSLEY, who wished to know why the Committee had changed their opinion in this matter, said that it was owing to a communication from Mr. Power, who did not see his way to oppose the amendment.

Dr. MACALISTER, although he believed it was dangerous to grant exemptions, was of opinion that if the Council thought that it was a hard case they could deal with it by accepting the amendment; but he considered that the whole matter should be referred to the Public Health Committee.

The amendment was then first carried, and then carried as a substantive motion. Dr. MACALISTER then moved, and Dr. BRUCE seconded, that the matter be referred to the Public Health Committee to be reported on next session.

The resolution proposed by Dr. MACALISTER, seconded by Dr. NORMAN MOORE, to receive place on the Minutes and adopt the Report of the Pharmacopœia Committee, was then carried.

Dr. NORMAN MOORE then moved, Dr. LITTLE seconded, and it was agreed to unanimously, that two votes of thanks of the Council should be presented: one to Dr. MACALISTER for his services in regard to international uniformity in the pharmacopœial remedies and the second to Dr. Payne, who, on retirement, had presented the Council with a copy of the earliest Pharmacopœia.

Dr. PYE-SMITH proposed, and Mr. TOMES seconded: "That the Report of the Finance Committee be received and entered on the Minutes. This was agreed to, and the report was adopted, after the three propositions it contained had been moved and seconded separately. These propositions had reference (1) to £1,000 received from the builders; (2) to the dental funds; and (3) to a loan from the Pharmacopœia Account.

Sir V. HORSLEY moved, and Dr. MACALISTER seconded that the report of the Preliminary Scientific Education and Examination Committee be received, entered on the minutes, and adopted. This was carried.

Moved by Sir VICTOR HORSLEY, seconded by Dr. WINDLE, and carried: "That the elements of embryology should be definitely associated with morphological zoology and included in the syllabus of Elementary Biology." (Extract from Para. 6 of the report.)

Moved by Mr. TOMES, seconded by Sir V. HORSLEY, and carried: "That the Report of the Medical Companies Bill Committee be received, entered on the Minutes, and adopted with an addition to the Appendix."

Moved by Mr. TOMES, seconded by Sir CHARLES BALL, and carried: "That the Report by the Dental Education and Examination Committee be received, and entered on the Minutes."

In moving the adoption, which was carried, Mr. TOMES, who was seconded by Dr. LINDSAY STEVEN, remarked that the Dental Board of Victoria, which had come into close contact with the University of Melbourne, had made every effort to make its licence up to date.

Moved by Sir HUGH BEEVOR, seconded by Dr. NORMAN MOORE, and carried: "That the Report by the Students' Registration Committee be received, entered on the Minutes, and adopted."

The Council then considered for a long time *in camera* the mode of procedure in the election of a President. When strangers were re-admitted, Sir W. TURNER made a few graceful remarks before relinquishing the Chair, expressing his deep acknowledgments for all the kindness, sympathy, and support he had received from the members of the Council during the discharge of his presidential duties, which last were occasionally, he admitted, of a rather trying character, and asking pardon if, during discussions,

he had, either in word or manner, hurt the feelings of any member of the Council. The President's words were very cordially received.

Sir PATRICK HERON WATSON proposed, and Dr. PYE-SMITH seconded, that Dr. MacAlister be elected President. This being agreed to, the proposer and seconder brought Dr. MacAlister into the Council room, where he was installed in the Chair by the retiring President. Dr. MACALISTER said a few words, thanking the Council for the honour conferred upon him, which he considered the greatest of his life, after which the members flocked round the new President to shake hands with him.

On resumption of business, Dr. MacAlister in the Chair, it was moved by Dr. NORMAN MOORE, seconded by Dr. McVAIL, and carried as an instruction: "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."

Leave was then given, on the motion of Sir CHRISTOPHER NIXON, for Dr. Mackay to postpone to the next session his motion, seconded by Sir WILLIAM THOMSON, with reference to Resolution 3 upon the Minutes of May 30th, 1904, in regard to Registers of Dental Students. A communication was then read from the University of Liverpool, asking for recognition by registration in the *Medical Register* of the Diploma in Tropical Medicine of that University. The PRESIDENT suggested as an answer that the Council, in the absence of special legislation on the subject, had no authority to direct the registration as an additional qualification or a diploma on tropical medicine. This was agreed to.

The PRESIDENT answered in the negative Mr. BROWN's question: "Whether the University of Cambridge had communicated to the Council its decision to establish an examination and to grant diplomas in Tropical Medicine and Hygiene."

Moved by Sir JOHN BATTY TUKE, and seconded by Dr. MACKAY: "That the legal advisers of the Council be requested to state an opinion on subsection 3 of Section 3 of the Medical Act, 1886, bearing on the obligation of the Council to forward the Reports of Visitors and Inspectors to the Privy Council in their entirety, irrespective of what they may contain."

At the suggestion of the PRESIDENT, the words: "as to whether an obligation rests on the Council," were inserted, and the motion, as amended, was carried.

A motion by Sir CHRISTOPHER NIXON, seconded by Sir WILLIAM THOMSON: "That in forwarding the reply of the General Medical Council to the letter of the Privy Council of November 1st, this Council desires to bring formally before the Lord President the suggestion made in the memorandum of the President of the Council, dated May 1st, 1903, that the Treasury should be urged to grant a sum sufficient to defray the expenses of the disciplinary functions of the Council" was withdrawn after a brief discussion.

The Council then went into *camera* to confirm the Minutes, and the session terminated.

#### CENTRAL MIDWIVES BOARD.

A MEETING of the Central Midwives Board was held on November 24th, Dr. F. H. Champneys in the chair.

A letter from Miss Oldham, resigning her position as a member of the Board representing the Royal British Nurses' Association, was received and accepted with regret.

A letter was received from the Honorary Secretary of the Metropolitan Counties Branch of the British Medical Association, enclosing a copy of letter addressed by the Branch to the London County Council and asking for the co-operation of the Board with the London County Council in obtaining powers from Parliament to pay registered medical practitioners when called in by midwives in emergencies. Upon

the motion of Mr. E. Parker Young, seconded by Dr. J. Ward Cousins, it was resolved: "That the Honorary Secretary of the Metropolitan Counties Branch of the British Medical Association be informed (1) that this Board agrees that statutory provision should be made for the payment of the services of a registered medical practitioner when called in by a midwife in accordance with the rules of the Board; (2) that the Board has already forwarded a resolution to this effect to the Privy Council."

After consideration of applications for certificates, the names of 1,068 women were passed under Section II. of the Act, and ordered for entry on the Roll.

In Section 1 Sub-Section (2) the Midwives Act states that no woman shall, after April 1st, 1910, habitually and for gain attend women in childbirth otherwise than under the direction of a qualified medical practitioner unless she be certified under the Midwives Act. In regard to this, the Clerk of the Monmouthshire County Council wrote asking the Board's construction of the words "otherwise than under the direction of a qualified medical practitioner."

It was decided that the Secretary should reply to the letter stating that the Central Midwives Board was unable to give a general answer to the inquiry because it was largely a legal question on which no authoritative decision had been given.

Dr. Ward Cousins said that at Portsmouth the County Council had received applications from several women to be put on the list of midwives who had received certificates from the Central Midwives Board, but were unable to read or write. It was decided that though the Board was bound to put on the roll any woman who at the time of the passing of the Midwives Act, had been for at least one year in bona-fide practice as a midwife, and bore a good character, nevertheless the local supervising authorities were not bound to have them on their lists.

#### REPORTS OF THE PROCEEDINGS.

Dr. Cullingworth moved: "That during the consideration of matters having reference to the judicial or penal powers of the Board, or of applications for recognition or approval on the part of institutions as training schools, or of medical practitioners as teachers the representatives of the Press shall be requested to withdraw."

Sir William Sinclair said he was sorry to hear Dr. Cullingworth move such a resolution. He might have waited till the representatives of the Press had given evidence of any want of judgment. The resolution proposed by Dr. Cullingworth required two or three words to make it complete, and those were to exclude the Press on all other occasions; and further, Dr. Cullingworth made so many exceptions that Sir William Sinclair said he really could not see on what occasions Dr. Cullingworth would trust the Press at all.

Mr. Parker Young said it was a protection to the public to have the proceedings of the Board in carrying out the duties of an Act of Parliament reported. He considered that the greater the publicity the better for all concerned.

The consideration of this subject was postponed for reference to be made to the procedure of the General Medical Council.

## Lunacy Department.

### LUNACY IN IRELAND.

THE Fifty-Third Annual Report of the Irish Lunacy Inspectors, which has recently appeared, affords considerable food for thought. From it we learn that a marked increase has again taken place in the numbers of the insane, there being 656 more in the Irish asylums at the end of 1903 than in the previous year, showing an advance of 104 over the yearly average increase for the past ten years—in fact, the increase is the largest

since 1898. All classes of asylums are affected by it except the criminal asylum at Dundrum (which shows a slight decrease), but the yearly augmentation in the numbers has chiefly taken place in the district asylums. The population of which is 9,427 higher than it was 23 years ago. One satisfactory point in so much that is gloomy is that the proportion of lunatics in workhouses, the unsuitable conditions of which for this class of inmates are notorious, continues to show a steady decrease, numbering 16 per cent. in 1903 as against 18 per cent. in the previous year, and 27 per cent. in 1880. This is notwithstanding the fact that an actual increase of 121 took place in the lunatic workhouse population in 1903, the suggested explanation being that a number of aged and dotting persons have been transferred to the lunatic wards from other parts of the workhouses.

It is reassuring to find, however, that the numbers admitted to the institutions of the county show practically no advance (three only) over those of the previous year; in fact, the number of "first admissions" is less by 48. That is to say, there has been no increase in the number of fresh cases of mental disease, and the increment of the asylum population must be due merely to accumulation. Nevertheless, this accumulation has to be dealt with, and we learn from this report that some of the asylums are already overcrowded, while, on the other hand, the necessity for making different arrangements for the lunatic inmates of workhouses is a pressing one. The principle of auxiliary asylums on the lines of that at Youghal is one which those who have had practical experience of the treatment of the insane almost universally distrust, and it would seem that the best way out of the difficulty would be some form of the colony or "boarding-out" system, which has been successful without exception wherever tried, including Scotland. It is sincerely to be hoped that this experiment will soon be legalised for Ireland. In the meantime blocks managed somewhat on auxiliary asylum lines, but in much closer association with the parent asylums, would probably afford the best means of reconciling the dictates of humanity with the shallow pocket of the Irish ratepayer.

The recoveries show an advance on the previous year, the percentage calculated on the admissions being 36.7, as against 35.8 in 1902. The death-rate is slightly higher than in the previous year. In view of the overcrowding alluded to above it is important to note that over one-fourth of the deaths was due to consumption.—a proportion, however, not greatly differing from that in other recent years. A regrettable falling off in the number of autopsies is reported, and we fail to find that any advance has been made with the project of a central laboratory.

Lastly, the return of the Census Commissioners is referred to, the most important point being the decrease in the proportion of idiots as compared to lunatics in 1901, probably owing to more accurate diagnosis.

### ALCOHOLIC INSANITY.

DR. G. M. ROBERTSON, medical superintendent of Stirling District Asylum, in his report for the year ending May, 1904, takes up the question of alcoholic insanity. He alludes to the satisfaction with which those interested in the care of the insane have observed the growing interest of the public in the action of alcoholism in producing mental disease. No single factor sends more men insane in this country than over-indulgence in alcohol. As it is a cause over the action of which absolute control can be exercised, it appears little short of criminal to allow this evil to exist unchecked by the State to the moral and material damage of its citizens. From May, 1894, to May, 1899, the proportion of alcoholic insanity was 20.1 per cent. for men and 6.6 per cent. for women—13.2 per cent. of the total admissions. The difference between the two sexes, whether it be owing to the different customs of men and women or the greater self-control and better morals of the latter, is so great that when the admissions of the two sexes are unequal the total percentage may

give rise to error of deductions from it if it is applied to the general population. The percentage of alcoholic insanity, allowing for this source of fallacy, rose from 13.3 per cent. in the quinquennium under consideration to 18.4 per cent. in 1900, and to 25.8 per cent. in 1901. It then fell to 20.1 per cent. in 1902, 18.1 per cent. in 1903, and back to 13.2 per cent. in 1904. The association of periods of good wages for the working classes with an increase of drunkenness and insanity has already been noticed, while cycles of bad trade and low wages tend to be accompanied by a decrease. An additional explanation of the apparent paroxysm of intemperance now happily passing off has been suggested by Lord Balfour of Burleigh. During the acme of this period the South African War was in progress, and, owing to large numbers of able-bodied young men having enlisted and left the country, the lowest class of labourer, for the first time for many years, got constant work and steady wages. His sudden good fortune was too much for his power of self-control, and the extreme excesses of his class made a substantial increase in the amount of alcoholic insanity admitted to this asylum.

#### LUNACY IN GLASGOW.

THE annual report on the certification of lunatics for the year ending May 15th, 1904, by Dr. Carswell, certifying physician in Lunacy to the Glasgow Parish Council, has just been published. It states that during the year, 886 applications were made to the Inspector of Poor on behalf of persons supposed to be insane, and as a result of the examination of these cases, 544 were certified and 342 uncertified. Of the 544 cases certified, 164 had suffered from previous attacks of insanity, the remaining 380 represent the actual number of persons who became insane for the first time during the year. The actual number of first attacks certified this year is seven less than last year, and the proportion per 100,000 of the population is 63.5, compared with 65.5 last year. This is the lowest production rate for four years. The figures show that at all ages under 45 insanity affects males and females almost equally; that at ages over 45 more men become insane than women, and both sexes become insane in larger proportion to the numbers living at those ages as they advance in years; and that there is a relatively larger number of persons sent to asylums at ages over 45 than under. The ages 15 to 45 are the most important in relation to the question whether lunacy statistics indicate a process of mental deterioration going on in the community; those are the ages of greatest stress and temptation and it cannot be said that a production rate of 8 per 10,000, relating to a section of the population numbering 300,000, is alarming. If the experience of the last four years is normal, as Dr. Carswell thinks there is reason to believe it is, then we are justified in interpreting the steady production rate as meaning that so far as the masses of the people were concerned there was no evidence of an increasing mental deterioration. Turning to the figures relating to the number of population to each public-house, Dr. Carswell shows that the general case is, that with a few striking exceptions a high lunacy rate is associated with a large number of public-houses in the district. The figures before us confirm that general view, but they give no support to the exaggerated views that have been expressed in various quarters that lunacy caused by alcohol is seriously increasing in Scotland.

### Correspondence.

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

#### THE MERE ANALYST AS AN EXPERT IN TOXICOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Considerable uneasiness has been caused to confectioners and others throughout the country because of a statement published in the daily papers, and attributed to a Belfast analyst, that tartaric acid, so largely used in effervescing drinks and in cake-making, is really

an irritant poison. This, of course, is absurd. There is, I believe, a case on record in which the ingestion of an enormous quantity of the acid—some 600 grains, was followed by death, and indications of irritation naturally existed; but in ordinary cases, where a dose of about twenty grains is taken and when the acid is almost always neutralised to a harmless salt, tartaric acid is not only not poisonous, but of much utility.

The analyst who delivered the *obiter dicta* is, of course, not a medical man, and I think the time has come for the profession to resent very keenly the utterances of mere analytical chemists on questions which pre-eminently require a training in physiology.

Some short time since practically all public analysts were medical men, and all recent reforms in toxicology and in the Food and Drugs Acts were due to their labours. Of late, not only have chemists ousted them from the merely technical part of analysis, for which they are possibly trained, but they now presume to pose as authorities on the most vexed questions of the effects of small doses of drugs on the human organism, and on other matters on which a man with a medical training only has a right to be heard. It is obviously not because a man is competent to detect a fraction of a grain of formalin in milk that he should be considered an authority on the question whether this amount was calculated to do harm.

I am, Sir, yours truly,

J. C. McWALTER, M.A., D.P.H., M.D. BRUX.  
Dublin, November 21st, 1904.

#### HOSPITAL FUNDS AND THE SMALL HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If the Hospital Sunday and Hospital Saturday and King Edward's Funds could be merged into a central hospital board, having some real power of control, it is certain that a great number of the small hospitals would soon cease to exist; reason for their existence being evidently lacking entirely. This applies particularly to special hospitals. These institutions may, with few exceptions, be divided into three classes—the unnecessary, the useless, and the sham. Many of them have grown out of the sham into the useful form, although most of these are unnecessary, seeing that the maladies they deal with are all provided for in general hospitals. Can any member of the profession affirm that there exists any real need whatever for separate hospitals for throats, or teeth, or skin diseases, or for deformities, or diseases of the eye or of the rectum, or for stone? Many such hospitals, if not most, have owed their origin to medical adventurers—men eager for wealth or finding themselves failures in practice under legitimate conditions—who have recognised a sham special hospital as a most effective cloak for personal advertisement—advertisement, moreover, paid for by the public out of the subscriptions to the hospital funds. Everyone with any view behind the scenes of medical life in London is aware how successfully this game was played years ago; and how the demoralising spectacle of worldly prosperity gained by such means brought forth numerous imitators. The profession, the public, and the poor would be all benefited by the closure of the majority of special hospitals, and if the incomes of these establishments, with the wasted funds the separate administrations give rise to, were transferred to the general hospitals the pressing needs of these would probably be at once almost fully satisfied.

I am, Sir, yours truly,

HENRY SEWILL,

Cavendish Square, November 30th, 1904.

[We print the above letter with pleasure as it represents a strong view of one side of the question. At the same time we think it right to point out that personal advertisement and professional experience are derived by holders of medical appointments in large hospitals just as much as in small—ED., M.P.&C.]

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The small special hospitals have a claim on the

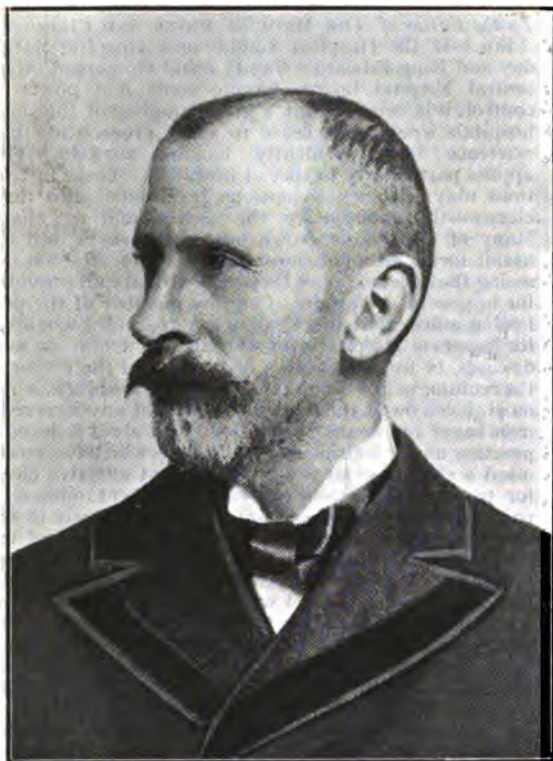


gratitude both of the medical profession and of the public. Fifty years ago they were the pioneers of specialism when special departments were unknown in the general hospitals. The Golden Square Throat Hospital is an instance in point, for there the foundations of modern laryngology were laid by the late Sir Morell Mackenzie, and there the laryngoscope found its first introduction in this country. Other classic instances are the Blackfriars Skin, the Moorfields Eye and the Soho Women's Hospital—not to mention the National Dental, the Cancer and the Brompton Consumption Hospitals. Many of these institutions started in the smallest and most unassuming fashion and have developed into great centres of scientific work and teaching. Who is to say that the small special hospital of to-day is not to bear fruit one day of equal value to the community. Lastly, under the conditions that rule the hospital medical world of London the only chance of any man not born into the purple lies in obtaining an appointment at a small special hospital. Is the medical alone of all professions to deny the chance of promotion to its rank and file. No, sir, the small special hospitals of London have done and are doing a noble work both socially and professionally.

I am, sir, yours truly,  
A SMALL HOSPITAL PHYSICIAN.

### Obituary.

GEORGE VIVIAN POORE, M.D.



In addition to our obituary notice of last week we have pleasure in publishing the following appreciative memoir of the late Professor Vivian Poore from Professor H. Kenwood, a friend and colleague:—

"As one who was for many years privileged to enjoy the friendship of Dr. G. V. Poore, the sad news of his death comes as a great shock and creates a sense of real and enduring personal loss. His unfailing charm of manner endeared him to all and not a few of us who have been associated with the work at University College and Hospital retain grateful recollections of

assistance in some form or other from one who was always ready with advice, help, and encouragement.

"His eminence as a physician is, of course, known to all, and there are many to testify to his exceptional teaching powers and his popularity with students; but it was mainly in connection with public health matters that I saw most of Dr. Poore. His interest in public health subjects generally was of the keenest, but it was mainly during the latter years of his active life that he gained notoriety by his able and strenuous advocacy of the principle of paying back to Nature the organic matter originally derived from it, by giving directly to the soil our solid and liquid dejecta. As an advocate of the dry system of sewage collection and the subsequent application of human dejecta to the soil in immediate proximity to dwellings, he occupied a position which met with curiously little sympathy from the rank and file of public health workers. The clever and logical advocacy of his views, supported as it was in public debate by exceptional rhetorical and oratorical gifts, rarely carried the entire conviction to the minds of those experienced in public health administration, who recognised (perhaps more than the difficulties and dangers involved in the practical application of his views, save in exceptional circumstances.

"Whatever he wrote or said upon this subject however, was always interesting and well informed, and his experimental work upon the subject in which he took so much interest will for long be studied and quoted as valuable contributions upon a matter regarding which it cannot by any means be said that the last word has been spoken. He was precisely one of those individuals in whom, despite the claims for respect and admiration which much good work of a high order demands the personality of the man predominantly asserts itself and constitutes him first of all an object of warm friendship. With Dr. Poore there passes away a kindly and courtly gentleman, a pleasant colleague, and a true friend."

### Medical News.

#### Medical Sickness and Accident Society.

THE usual monthly meeting of the Medical Sickness Annuity and Life Assurance Society was held at 420, Strand, London, W.C., on November 25th. There were present: Dr. de Havilland Hall (in the chair); Dr. J. Brindley James, Dr. Frederick S. Palmer, Dr. J. W. Hunt, Dr. St. Clair B. Shadwell, Dr. F. J. Allan, Dr. W. Knowsley Sibley, and Dr. J. B. Ball. The accounts presented showed that the sickness experience of the Society was about the same as usual at this time of the year. The recent cold weather produced a rather large number of claims but they were not for the most part of a serious nature, and the business for the whole year will probably show a fair margin in favour of the Society. A considerable number of the members have been laid up through septic wounds, but as all accidents as well as illnesses are covered by the certificates of the Society, full pay has been allowed in every case. Prospectus and all particulars on application to Mr. F. Addiscott, Secretary Medical Sickness and Accident Society, Chancery Lane, London, W.C.

#### Suggested Visit to Paris.

A MEETING of medical men was held in Paris on November 25th, when it was resolved to invite British physicians and surgeons to pay a return visit to Paris. Professor Bouchard, member of the Institut, was elected President of the Paris Committee, and the opinion was expressed that some date early in May—probably between May 7th and 14th—would be most convenient.

#### Badly Ventilated Schools at Burnley.

DR. DEAN, the Burnley medical officer of health, reporting on the measles epidemic, severely condemns the lack of ventilation and overcrowding of class-rooms. In one case he found the air almost unbreathable, the class-room overcrowded, and the infants sleepy and half-poisoned.



**Cyllin and Creolin in the Law Courts.**

A CASE has just been decided in Germany relative to the bactericide and disinfectant called "Cyllin," which is of interest to the medical profession. The right to the word belongs exclusively to the Jeyes' Sanitary Compounds Company, Ltd., of London, who coined it as a substitute for the trade-mark "Creolin," formerly used by them, and which they claim to be very much more powerful in bacteria-killing efficacy than that represented by the original title. Finding that Creolin was still being sold in Germany by the Pearson Company of Hamburg as Jeyes' preparation, the latter company published a statement to the effect that the fluid which they now make (Cyllin) is four times the strength of that which they formerly sent to Germany as "Creolin." Consequent on this statement Mr. Pearson took action against the company in the District Court of Hamburg, and the Court, having referred the matter to the Hygienic Institute of the city, Dr. Kister, of the Institute, was deputed to examine a long series of specimens. That authority reported, as the result of bacteriological experiments, that the defendants (Jeyes) had succeeded in quadrupling the bacteria-destroying properties of the fluid formerly supplied to Germany by them under the name of "Creolin," and that "Cyllin" is eleven times stronger than pure carbolic acid. With this expert testimony, judgment has just been pronounced by the Hamburg District Court in favour of the English company, and the plaintiff's claim dismissed with costs.

**Liverpool Hospital Saturday Fund.**

THE annual report of the Liverpool Hospital Saturday Fund showed the largest advance in any one year since 1873, the total collection from all sources (including £646 4s. 5d. from the ladies' street collection) being £9,007 16s. 4d., as against £8,062 18s. 1d. in 1903, an increase of £944 18s. 3d. The workshop or general fund was still moving upwards, £8,006 14s. 3d. being subscribed, which was £603 16s. 5d. more than last year. The ladies' street collection also showed a very creditable improvement. The total expenses only amounted to £532 10s. 4d., or about 5½ per cent., against 6½ per cent. in 1903. The amount distributed to the hospitals in connection with the Hospital Sunday Fund was £14,850, or £250 more than last year. Of this the Hospital Saturday Fund's share was £8,363 2s. The total number of collections was 3,610; boxes, 2,385; cards and lists, 1,973; and firms using own methods, 152. The total in 1903 was 3,423.

**Royal College of Physicians of England.**

THE Council of the College invite applications for the office of Milroy Lecturer for 1906. The course must comprise not less than "three" nor more than "six" lectures, and are to be given on Tuesdays and Thursdays in February or March, 1906. Applications must be addressed to the Registrar, on or before January 7th, and should contain a statement of the division of the subject selected by the candidate. A copy of Dr. Milroy's "Suggestions" on the subject of his bequest, and information as to the emolument, may be obtained from the registrar.

**Royal Waterloo Hospital for Children.**

THE lady who had so generously offered to endow a cot in the Royal Waterloo Hospital for Children and Women, on the condition that five others will come forward and do the same, has found a worthy supporter in the Executors of the late Mr. Arthur O. Crooke's will, who bequeathed £20,000 to the Hospitals of London and Surrey. These Executors have given the sum of 2,000 guineas to the above hospital, which enables the Board to endow two more beds, so providing three of the number stipulated.

**PASS LISTS.****Royal College of Surgeons, England.**

THE following having passed the necessary examin-

ations and having conformed to the by-laws have been admitted members of the college, viz.:—

L. A. Arnould, T. Bates, and J. A. Bell, St. Bartholomew's; J. Avery, London Hosp.; W. G. Aviss, Birm. Univ.; J. H. Banks, St. George's; H. E. Barrett, St. Mary's; J. F. Beale, B.A.Camb. and London Hosp.; A. R. Beaumont and A. M. Benett, Guy's; C. H. Berry and J. H. D. Bolton, Univ. Coll. Hosp.; A. Blanc and J. H. Burrigge, King's Coll. Hosp.; G. H. Boyden, Edin. Univ., Owens Coll. Manchester, and St. Thomas's; A. C. Brown, St. Bartholomew's; A. H. Burnett, Edinburgh Univ. and London Hosp.; G. Carlisle, Guys; H. Chitty, Univ. Coll. Hosp.; S. H. Clarke, B.A.Camb. and London Hosp.; A. P. Coker, L.S.A.Lond. and Middlesex Hosp.; J. Cook, Univ. Coll., Cardiff, and Guy's; D. K. Coutts, St. Thomas's; A. W. D. Coventon, M.A., B.C.Camb., and St. Bartholomew's; G. F. Dalton, M.D., C.M., Kingston, Ontario, and Middlesex Hosp.; T. S. Davies, Univ. Coll., Bristol; H. R. Dean, Oxford and St. Thomas's; G. De la Cour, Univ. Coll. Hosp.; C. H. Denyer, Guy's; F. L. De Verteuil, Edin. Univ., St. Thomas's, and King's Coll. Hosp.; C. M. Dickinson, London Hosp.; G. R. Ernst, M.D., Rush Medical Coll., Zurich and Berlin Univs.; G. J. Evans, St. Mary's; C. R. B. Eyre, St. Thomas's; R. Felton, Guy's; L. C. Ferguson, St. Bartholomew's; A. R. Finn, St. Mary's; W. J. Fordham, Univ. Coll., Sheffield; F. Forrest, Edin. Univ. and Victoria Univ., Manchester; C. J. Galbraith, King's Coll. Hosp.; H. Hardwick Smith, M.A. Camb. and St. Bartholomew's; A. E. U. Hawkes, L.S.A.Lond., St. Mary's and Univ. Coll., Liverpool; E. C. Hayes, New Zealand Univ. and St. Bartholomew's; S. C. Hayman, Univ. Coll., Bristol; T. B. Henderson, M.B., B.Ch., Oxon, and St. Thomas's; W. R. Higgins, Camb. and London Hosp.; L. Hill, St. Mungo's Coll., Glasgow, and Middlesex Hosp.; J. C. L. Hingston, Middlesex Hosp.; R. F. V. Hodge, B.A.Camb. and St. George's; A. H. Hudson, St. Thomas's; C. L. Isaac, Camb. Univ. and St. Mary's; B. J. F. Jackson-Taylor, Univ. Coll., Bristol, and King's Coll. Hosp.; F. A. G. Jeans, M.A.Camb. and Univ. Coll., Liverpool; E. C. Johnston, Westminster Hosp.; G. F. Jones, Univ. Coll. Hosp.; O. W. Jones, Univ. Coll., Liverpool; A. E. Kerr, Camb. and St. Thomas's; F. C. R. M. Knight, A. E. F. Kynaston and A. Leeming, Guy's; E. B. Lathbury and E. Leverton-Spry, St. Bartholomew's; G. Laurence, Univ. Coll., Liverpool, and St. George's; W. Lister, Univ. Coll., Leeds, and St. George's; A. S. Littlejohns, Camb. Univ. and Guy's; J. MacArthur and R. H. Miller, St. Mary's; J. McCrae, B.A., M.B., Univs. of Toronto and Montreal; J. A. McIlroy, Birm. Univ.; W. T. P. Meade-King, Guy's; W. M. Mollison, M.A., B.C.Camb., and Guy's; W. P. Morgan, M.A.Camb., B.Sc.Lond., Univ. Coll., Cardiff, and St. Mary's; J. F. Murphy and J. Papa Nicolas, London Hosp.; A. Nell, Ceylon Medical Coll., Univ. Coll., and Charing Cross Hosp.; L. E. C. Norbury and E. W. Parry, St. Thomas's; C. W. O'Brien, St. Bartholomew's; C. E. Palmer, B.A. Camb. and St. Thomas's; C. Parker, L.R.C.S. and P. Edin., L.F.P.S.Glasg., and Westminster Hosp.; R. N. Poignand, B.A.Camb. and St. Thomas's; L. E. Price, Birm. Univ.; G. H. Rees and F. Rogerson, Guy's; A. Reute, Univ. Coll., Liverpool; H. G. Sievwright, Univ. Coll., Cardiff, and St. Mary's; J. D. Sinclair, Edin. Univ.; W. H. Smalles, Leeds Univ.; G. R. Southwick, M.D., Harvard and Boston Univs.; M. Spotswood, Liverpool Univ.; C. M. Stevenson, Guy's; H. V. Swindale, Middlesex Hosp.; A. G. Sworn, Univ. Coll. Hosp.; W. A. Tatchell and J. Turtle, London Hosp.; R. J. C. Thompson, St. Thomas's; A. W. Wakefield, Camb. Univ. and London Hosp.; T. R. Waltenburg, M.A.Oxon., B.A. Durh., L.S.A.Lond., and Owens Coll., Manchester; A. C. Warren and J. K. Willis, B.A.Camb. and St. Bartholomew's; R. G. Williams, B.A.Camb. and St. Bartholomew's; R. A. Worthington, Camb. Univ. and London Hosp.

## 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.

**PENSATOR.**—We have carefully considered our correspondent's offer, but, regretfully, we are compelled to decline it.

**M.R.C.S.**—Our correspondent will see that the matter to which he refers is commented upon in our editorial columns.

**M.D. (BRUX.)**—Application should be made to the Home Office.

**PRACTITIONER.**—The dispute which, it appears to us, is a trivial one, should be submitted to the arbitration of a mutual friend.

**STABILITAS (Devon).**—If the patient refused to follow your instructions and to wear the splint, your responsibility as to results is clearly waived. Any action he might bring would be precluded to failure, although it might involve you in a good deal of trouble and annoyance. The best way in dealing with such a patient would have been to point out the possibility and the likelihood of bad results if your directions were not obeyed, and to have washed your hands of the whole case when he remained obstinate. Many an ununited fracture has been brought about by mulish obstinacy of that kind.

**W. G. LAMBERT (Luton).**—The case of the medical man who wants a suture only upon rare occasions is exactly met by the aseptic threaded needles now to be bought in sealed glass tubes which are broken at one end when wanted, and the ligature and needle taken out.

### ORIENTAL GRATITUDE.

The *Daily Telegraph* reports that according to a despatch from Kittanning, Pennsylvania, Dr. C. A. Flower, who was mysteriously called to St. Louis a week ago, returned loaded with Oriental presents and documents to show that he had been appointed house physician for life to the Rajah Tipoo Sahib, a potentate of India, who after seven years' search found the physician who dragged him from under a camel and saved his foot from amputation. Dr. Flower, who is a wealthy man, says he will go to India in April and spend the remainder of his life there.

**DR. FIELDEN.**—Your paper has been marked for early insertion. Dr. C. H. B. (Brighton): We regret our inability to insert our correspondent's letter as it would open up a religious controversy, which would be out of place in a medical journal.

**RUTHERGLEN.**—The National Association for the Prevention of Consumption was inaugurated at Marlborough House, under the Presidency of his Majesty the King, when Prince of Wales, on December 20th, 1898.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY DECEMBER 7th.

**OBSTETRICAL SOCIETY OF LONDON** (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Sir W. J. Sinclair, Dr. Lewers, Dr. Williamson, Mr. J. D. Malcolm. Short Communication:—Lieut.-Col. Sturmer: On a Case of Abdominal Gestations. Paper:—Dr. W. Tate: Three Cases of Intestinal Obstruction following Operations for Fibroid Tumour of the Uterus, with Special Reference to the Choice of Operation.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m. Mr. J. Bland Sutton: The Surgery of the Uterus. 7.15 for 7.30 p.m. Annual dinner at the Trocadero Restaurant, Ficcaddilly Circus, W.

**CENTRAL LONDON THROAT AND EAR HOSPITAL** (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Dr. W. Wingrave: Ear.

THURSDAY, DECEMBER 8th.

**BRITISH GYNECOLOGICAL SOCIETY** (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Macnaughton-Jones, Prof. J. Taylor, Dr. Eider, Dr. R. T. Smith, and Dr. E. Fenwick. Paper:—Mr. W. Alexander: Adenoma of the Endometrium (illustrated by microscopic sections, photographs and lantern slides).

**BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY** (20 Hanover Square, W.).—5 p.m. Paper:—Dr. N. H. Forbes (Tunbridge Wells): Observations on the Climate and Health Resorts of Scotland.

**OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM** (11 Chandos Street, Cavendish Square, W.).—8 p.m. Clinical Evening. Cases and Specimens will be shown by Mr. E. H. Jones, Mr. G. W. Roll, M. A. Lawson, Mr. A. H. Thompson, Mr. D. Marshall, Mr. J. H.

Parsons, Mr. G. W. Thompson and Mr. E. Chatterton, Mr. G. Costes, and Mr. J. W. Tomlinson.

**HARVEIAN SOCIETY OF LONDON** (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Discussion on the Treatment of Pulmonary Tuberculosis (opened by Dr. Mackenzie). Sir W. Broadbent Bart., Dr. J. K. Fowler, Dr. S. Thompson, Dr. W. Ewart, Dr. C. Bate, Dr. Maguire, Dr. J. J. Perkins, Dr. J. E. Squire, and others will take part in the discussion.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchings: Clinique. (Surgical.) 5.15 p.m. Dr. P. Stewart: Paralysis of the Cervical Sympathetic.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Dr. G. N. Meschen: Skin Disease in Children.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture:—Dr. P. W. Price: Mitral Stenosis (illustrated by cases). Post-Graduate Course.)

FRIDAY, DECEMBER 9th.

**CLINICAL SOCIETY OF LONDON** (25 Hanover Square, W.).—8.30 p.m. Papers:—Mr. C. Wallace: A Series of Intussusceptions in Children.—Mr. H. White: A Case of Acute Rheumatoid Arthritis.—Dr. R. Abrahams: On Arthritis Deformans and its Allies.

**EPIDEMIOLOGICAL SOCIETY OF LONDON** (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Lecture:—Dr. Nuttall: Ticks and Tick-transmitted Diseases.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. H. W. Dodd: Clinique. (Eye.)

TUESDAY, DECEMBER 13th.

**THE MEDICO-LEGAL SOCIETY** (in the Rooms of The Royal Asiatic Society).—8 p.m. Exhibition of four Medico-Legal specimens by Dr. Harvey Littlejohn. Discussion: Degeneration: Its Causes and Prevention—with reference to the proposed Sterilization of certain Degenerates. To be opened by Dr. Robert Rentoul.

## Vacancies.

Stirling District Asylum, Larbert, N.B.—Assistant Medical Officer. Salary £150 per annum, with board, &c. Applications to the Medical Superintendent.

White Moss Sick and Accident Society, Skelmersdale—Medical Officer. Salary £200 per annum. Applications to the Secretary London Hospital, Whitechapel, E.—Medical Registrarship. Salary £100 per annum. Applications to E. W. Morris, Secretary.

Whitehaven and West Cumberland Infirmary.—Resident House Surgeon. Salary £120 per annum, with board and lodging. Applications to Wm. H. Sands, Secretary.

Nottingham General Hospital.—Assistant House Physician. Salary £100 per annum, with board, lodging, and washing in the Hospital. Applications to the Secretary.

Nottingham General Hospital.—Assistant House Surgeon. Salary £100 per annum, with board, lodging, and washing in the Hospital. Applications to the Secretary.

The Victoria Hospital for Burnley and District.—Resident Medical Officer. Salary £100 per annum, with residence, board, and washing. Applications to 7, Grimshaw Street, Burnley.

County of London.—Assistant Medical Officer. Salary £500 per annum. Applications to The Clerk of the Council, County Hall, Spinning Gardens, S.W.

## Appointments.

DEVINE, HENRY, M.R.C.S., L.R.C.P. Lond. Assistant Medical Officer at the Wakefield Asylum.

GROVES, ERNEST W. HER, M.D., B.S., B.Sc. Lond., Demonstrator of Anatomy at University College, Bristol.

SAVILL, AGNES F., M.D. Glasg., M.R.C.P. (Irel.), Honorary Assistant Physician to St. John's Hospital for Diseases of the Skin, Leicester Square.

THOMSON, WILLIAM TRAILL, M.R.C.S., L.R.C.P., House Surgeon to the Warneford Hospital, Leamington.

TOVEY, ARTHUR, M.R.C.S., L.R.C.P. Lond., Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square.

## Births.

DARGAN.—On Nov. 22nd, at 45 Stephen's Green, East, Dublin, the wife of William Dargan, M.D., of a son.

## Marriages.

POPE—OWLES.—On December 1st, at the Parish Church of St. Mary's, Barnes, Edwin Lonsdale, third son of Alfred Crosby Pope, M.D., of Cliftonville, to Florence Ada, second daughter of Charles Henry Owles, of Scarth House, Barnes.

WOODS—HAMPTON.—On Dec. 1st, at the Parish Church, Ewelme, Oxon, Major Albert Edward Woods, Indian Army, Assam Commission, of Bushey, Herts., youngest son of the late W. H. Woods, M.D., M.A., T.O.D. et Oxon., Surgeon R.N., to Audrey Katherine Mary, elder daughter of the late Prebendary E. K. Hampton, rector of Cradley, Herefordshire, and of Mrs. Hampton, Ewelme.

## Deaths.

MOTT.—On December 2nd, at "Wilderhope," Sedlescombe Road, St. Leonards-on-Sea, Dr. Charles G. Mott, eldest son of the late Charles Mott, of Church Streeton, Salop, in his 86th year.

SCRIVEN.—On December 2nd, at Abberly, Stourport, John Swain Scriven, M.D., B.N., aged 68, late of Duffield, Derby.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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## Original Communications.

### AN OBSCURE FORM OF ALCOHOLISM INVOLVING IRRESPONSIBILITY. (a)

By T. CLAYE SHAW, M.D., F.R.C.P.

OF all the causes or mental conditions which eventuate in murder or self-destruction, none is so frequent or powerful as drink, whether acting directly or indirectly. The imbecile or degenerate is easily led into crime by impulse when he has had drink, but under ordinary circumstances his very stupidity makes him tolerant—or indifferent—to anger-stirring causes, which would strain the balance of a higher equipoised intellect. Jealousy and revenge will hesitate for years on the brink of action, but they plunge boldly into accomplishment under the compelling force of drink. The scientific, calculating murderer is rare, and he is, as a rule, careful in his methods, and patient and deliberate in his tactics; he knows that alcohol would lead him to carelessness and risk of failure, and he keeps away from excess of it. In all ways drink is the beginning of the end. It has had its good results when leading to babbling by the accomplices in unlawful enterprise, but it is the ban of secret societies, and its powers of denudation are so well recognised that no one who is a slave to it can be trusted, for henceforth the veil is torn away from the inner mind, and he has lost the proprietorship of himself.

So immediate is the connection between drunkenness and crime that all the details of it should be well analysed with the view to explaining the question of responsibility, and I propose to draw the attention of the Society to one phase where the signs of inebriety are so masked (though the real loss of inhibition is intense) that only by a special consideration can we come to a right conclusion as to whether the individual is to be held responsible or not. One reason why secret societies flourish best abroad is that drunkenness is more rare. I am not a Freemason, but it has often struck me as strange that out of the thousands of male patients with whom I have been brought in contact, not one has ever divulged by sign or word any one of the mysteries of that very close corporation. To the uninitiated the fact suggests that either the obligation to secrecy is so overpowering as to be an unassailable inhibition, or else that there is no secret or mystery to disclose.

The question of responsibility in criminal cases—which it is, understand, the proprium of the jury to decide—has perhaps a different meaning as applied medically and legally. The law takes no notice of a man getting drunk as long as he is not incapable or disorderly, and it holds him responsible for his actions, which seems to be logical; but the physician knows that when a man is drunk he is not medically responsible, his voluntary actions become reduced to impulsive ones, he acts upon motives which in his true character

would have been restraining ones. Law and medicine are not likely to agree, therefore, upon this question of responsibility until the former recognises that character is the ultimate cause of will, and that whatever changes the character modifies the will, and therefore changes the conditions of responsibility.

In the earlier stages of intoxication we notice how the upper centres of the brain become involved, at first showing instability (which many mistake for brilliancy), then going on to incoherence, and finally to exhaustion or to coma due to toxamia. After a time, varying with capacity for elimination of the poison, resistive power of the nerve-elements and other causes, the intellectual paralysis ceases, and the parts resume function in the inverse order from that in which they disappeared, *in the majority of cases*; but there is a class where this complete recovery does not really occur, though the individuals regain the power of the ordinary reflex brain functions to so complete a degree as to deceive those with whom they are usually in contact, whilst they are at the time in a state of minus inhibition, and are really very dangerous persons both to themselves and others. To the ordinary observer they would pass for sane persons, but they are really unfit for responsibility, and their acts are more like those of somnambulists, or of persons in the stage of recovery from an epilepsy.

Some time ago the head of a large Government institution asked me the explanation of a condition which he occasionally found in some of the workmen, and which was attended with dangerous results, though the condition, which he attributed to drink, was of a character very special in its nature, and characterised by absence of many of the usual indications of intemperance. The rules at this institution in question are very drastic on the subject of intemperance on the part of the officials, and it transpired that though the workmen did not (perhaps could not) indulge in drink by day, they did so exceed at night, in the hope that probably the effects would not be visible the next morning, and that they would be able to carry on their duties undetected in their bad habits. On more than one occasion it was reported to the chief that men who had come in to work, to all appearances in a proper condition, had in the course of the day committed acts foreign to their previously understood nature, and in more than one instance of a suicidal character. In particular, one man, who was an old-established servant, came in to work as usual, but after a few hours made an attempt to poison himself by oxalic acid. It was found on inquiry that the man had done his work as usual, and been able to converse; though how far his intercourse with other people had gone was not stated: probably it was not much beyond slight references to the usual work or the commonplaces of the institution. It appeared afterwards that the man had been a heavy night drinker, but had always been punctual on duty in the mornings.

It has occasionally been remarked that people who have left off drinking for a short time have become suicidal or even insane when it might have been supposed that the ill-effects of the drink should have disappeared, though as a fact the higher centres would appear not to have regained their lost power, and in

(a) A Paper read before the Medico-Legal Society, London, November 8th, 1904.

reality an impulsive state was present. I have often remarked in lunacy practice that the insane symptoms have come on after the drinking habits had been discontinued for a few days or even longer, and though it would have been difficult to have demonstrated that these people were still under the influence of drink, and therefore impulsive and uncertain, there could be really no doubt of it in the light of subsequent events. These conditions are always very puzzling to those who meet with the victims in the apparently sane intervals, and without doubt they have been the cause of miscarriage of justice before now, because the persons so suffering have been judged to be in the possession of faculties to which they were really not entitled.

It would not be difficult to propose theories for the interpretation of these cases. It might be supposed that between the intervals of drinking and the appearance of the insane or dangerous symptoms and acts the patient had been unable to take food and rest and therefore had become weak, though possessing his faculties because he showed no prominent signs of perturbation; or that possibly during the interval some ptomaines had been developed which caused the subsequent explosion; and this is a by no means improbable explanation, though pathology is as yet scarcely ripe for this interpretation.

I remember being called in to see a gentleman whose delusions (of an exalted nature) were very prominent. I suspected that the condition was of alcoholic origin, and so it turned out, but I had considerable difficulty in eliciting the fact from the friends, because they said that though he used to take a good deal, he had recently not taken any, and therefore alcohol could have had nothing to do with it. Over and over again I have seen cases where alcohol has produced suicidal or homicidal conditions, an interval elapsing between the cessation of drink and the outbreak of the attack, nothing wrong being in the meantime noticed by casual observers. Please note that I do not mean to say that a proper examination would not detect some abnormality or impairment of function, but that to those in his casual surroundings, judging only by the way in which methodical or ordinary routine duties were performed, there seemed to be no change. Minute investigation would probably have disclosed incapacity for attention to new subjects, irritability of temper, instability, and change in emotional tone, all pointing to an impulsive condition and loss of inhibition.

Clinically we note that the effects of alcohol are either immediate in producing the delirium and excitement familiarly known as drunkenness, or in chronic changes which gradually set up organic faults in the nervous and general system, leading to slow loss of normal function, or else in the condition which I am describing, and which has not hitherto received the attention it deserves. I can best describe the state as one akin to shock of a partial kind, as if, whilst leaving the lower centres free to act, the upper centres were for the time in a greater or less degree of paralysis, the general condition of inanition of the system with its impairment of appetite and want of proper sleep causing a depressed emotional tone, and perhaps a distorted functioning of such parts of the higher centres as may be capable of action of some sort.

A parallel course is not uncommonly seen in mental shock on the receipt of bad news, where some time after the stunning effect of the primary blow, the usual organic functions being in the meantime performed as is customary, other signs of irregular mental processes appear, due to the *gradual* re-integration of centres that have been profoundly, but not irretrievably, damaged.

That illegal acts are not infrequent (indeed are only to be expected) in other conditions where, the lower centres being left in action, the upper ones are partially or wholly incapacitated, is well shown in a case which came under my notice, of a gentleman who was indicted for indecent exposure before some children

in the street. Evidence was to the effect that this gentleman, who was said to be rather addicted to stimulants, had an attack of the nature of a fit, and that a short time after when in the street, he undid the buttons of his trousers in the presence of some children and passed urine publicly. I had little difficulty in showing that the act was merely a reflex one, done without premeditation, and indeed in all probability unconsciously. Owing to fluid drinking, the bladder had become surcharged, then came the fit and its after effects, which set up a subconscious condition, whilst the sensation of stress of urine put in action the usual reflex act of unfastening the dress, &c., regardless of the public circumstances under which it was done. The man was acquitted of criminal intent, owing to temporary disablement from disease.

In order to understand this class of cases, we have only to consider the doctrine of evolution propounded by Dr. Hughlings Jackson. The highest brain structures are the last to be evolved; they represent the most complete development of inhibition and will. In the acquisition of habits and of business they are regulative and determining, but this co-operative function once brought about, the carrying on of the process is relegated to lower centres which are able to perform unaided the work which has been put upon them; they are more automatic, less voluntary, more organised, than are the structures above them; they are also less liable to impairment by poison (such as alcohol) and disease, and a little consideration will show how many of the ordinary exchanges of conversation and action in social life are but the exercise of these subordinate agents.

"Man thinks little and thinks seldom," says Wundt. Were it not so the fatigue of life would be too great. Much repetition reduces the emotional tone so that we react without strain, almost without consciousness, processes which may have cost much thought and much attendant feeling to acquire.

When will-power and the higher mental faculties such as attention are masked, the lower or subconscious faculties still react in obedience to external or internal stimulus, and this form is either of a simply reflex character, or it issues in impulsive display. Action on impulse is often of a dangerous character, sometimes it is conservative. It is the mode of action of the untutored mind of the child and of the mind which has fallen from its high estate. It is the mode of the hasty and impetuous, and it is the method adopted by Nature for the safety or destruction of the individual at a crisis, issuing sometimes in the one, sometimes in the other. Certainly it is the action of the incomplete mind, and therefore it connotes irresponsibility.

The routine of life is attended with so little vivid consciousness that it is often difficult to say what has transpired, so little attention do the customary processes call forth, and even in the best educated classes, where there is wider orientation of thought owing to greater range of associations, the same reduced process is at work during the greater part of the social life. In fact the higher centres are out of function for long periods at a time, and the coruscations that surprise the ordinary person are but the flashes of light rendered visible when the chief part of the greater centre is obscured.

To define accurately the line of margin between responsibility and non-responsibility is impossible. Men may write coherent letters, may dictate the disposal of their property and of their remains, may go about their ordinary work and social observances, and yet be meditating suicidal or homicidal acts all the time; there is no key to the inner life and motives of a man beyond his acts, and even these can only be relatively estimated. When they (the acts) clash with the ordered social codes we must conclude that the actor is either criminal or insane, or of some innate mental peculiarity; in the former and latter conditions he may or may not be responsible; in the middle term he is certainly not.

*Post-mortem* examination of any brain would show

imperfection. It is a fact that microscopic exploration shows defects and deteriorations in what have been considered to be thoroughly healthy minds, and if so, who shall determine the effect of these intimate, if minute, lesions upon processes of mind? To me they account for many of the shortcomings of which we are ourselves conscious, but of which the outside world is ignorant and refuses to condone.

A well-known present-time actor said to me the other day that the greatest difficulty connected with the stage was having to perform a part when under the stress of worry or anxiety, and yet the audience would know nothing of this inner mental state obscured to public gaze by the function of subordinate centres which they are all the time mistaking for the higher processes, which are in reality very differently occupied. If men would only recognise how uncertain their responsibility is, how incapable they often are to form correct judgments where their own interests are concerned, and how vital it is for the community that they should seek the advice of others whose higher centres are unimpeded by personal considerations, there would be less crime and fewer mistakes. He who goes to his lawyer, his doctor, his priest, or his friend obtains relief because he is substituting for a limited and untrustworthy hierarchy the judgment of an unbiassed mind, free to act because recognisant of the conditions involving responsibility.

It is the knowledge of the imperfect integrity of brain structure in the highest regions which often causes conflict between the lawyer and the physician; the former sees the codes transgressed or evaded, and would make the individual responsible because there is apparently nothing wrong in the ordinary reflexes of social life; the latter knows that the highest and most delicate centres are rarely complete and able to function regulatively, and he therefore hesitates before allowing responsibility.

Incomplete function in any other viscus than the brain is every minute before our eyes, but as it rarely leads to anything beyond inconvenience to the individual it is not of so much importance to the community; but when the brain is impaired no one can forecast what will happen to the individual, or to society.

I look upon the law-lists as evidence more of disease than of wickedness, and the lawyer and the physician as allies in the corporeal and spiritual treatment of the infirmities of crime and insanity. It may be objected to the above interpretation that punishment often prevents the repetition of crime. This I quite admit, but it has nothing to do with the question of responsibility. The conditions of punishment often act medically and enable a disordered or impaired organ to recover its equilibrium; in some cases punishment comes as a relief, the individual feels that his debtor and creditor account is balanced, stress is relieved, and the overburdening of a paralysed centre is cast off; but to proceed to the ultimate resort of doing away with the individual for all time is a process which should only be carried out under the most particular circumstances; in my opinion, the extreme penalty of the law should rarely be visited on women; they are too delicately organised, their mental integrity is too easily destroyed, their impulses and emotions are beyond our ken, and therefore we can only judge them by an inadequate standard.

Is it not for medicine to determine the conditions of responsibility at the time, and for the moral physician, the lawyer, the toll to be paid?

### SOME CLINICAL EXPERIENCES.

By WILLIAM H. PEARSE, M.D.Ed.,  
Consulting Physician, Plymouth Public Dispensary.

*Verge of Poisoning.*—A little personal experience of one's own case may be worth recording, as it suggests truths accurately observed.

I was perfectly well and in the best of spirits on a

certain day; after a light lunch, I took a pleasant journey of eight miles by rail into the country, where with friends I had a light tea, but including Devonshire cream and stewed bottled prunes. I am inclined to think that the cause of my illness was more in the bottled prunes than in the cream. On returning home, I felt uncomfortable, took a cup of *café noir*, going to bed at 11.30; a feeling of nausea came on; about every four minutes a severe pain extended round the lower ribs, and which lasted, on each occasion, about one minute; the pain was most severe, seemingly, in the liver. The pain came like an even band around the ribs. I now and then drew a deep breath to find out if any inflammation existed in the pleura or surface of the liver. After three hours of such feeling of nausea and pain, associated with much depression, I poured up, three or four times, great streams of vomit, and in ten minutes felt well.

What is interesting, pathologically, is the wide region of the pain, and especially the very marked pain in the liver. The hypothesis arises, that the cream or prunes passed slowly into a mode of "poison"; that the "unconscious memory and will" of the cells of the liver, resisting the entrance of inharmonic modes and motions—"poisons"—into the system, passed into a heightened action, with the evolution of what one may call a "mode of motion," a "will" resistance—pain. I ate the cream between 5 and 6 p.m., but did not vomit until 3 a.m.; thus we have a record of the time involved in such processes of poisoning. The case is interesting in another aspect, *viz.*, as illustrating the phenomena of epigastric neuroses and indigestion of neurotic type, the aspects of which are so very varied, and which, without much care, and without a wide general view of many functions and their correlations, are apt to lead us astray, both in diagnosis and treatment.

*Arterial Embolism.*—Thirty years ago a gentleman, *æt.* 50, of fine physique and of active habits, carried a heavy Portland vase down one and up another flight of garden steps. I was called the day after; he was in bed. The heart's action was rapid and most irregular. I gave him entire rest for a week. From that day to now the heart's action has been irregular; but in my very numerous examinations during thirty years, I have never heard a bruit. In 1890, the heart's action became, for a few weeks, slow, the pulse sometimes from 50 to 60.

The general health during thirty years has been good. He has had, however, in two or three winters, some bronchial attacks, and, rarely, a little diarrhoea.

In January, 1902, he fainted, or semi-fainted. I found the heart most irregular and feeble in impulse; the left thigh and leg were cold. I could find no pulse in the left femoral artery, nor in the iliac as far as I could reach over and above the groin. The left iliac and femoral arteries seemed blocked. The leg and thigh swelled greatly for two or three weeks, the skin being very tense; during the same period, the patient suffered much pain over the gluteal region and back of thigh, seemingly due to the compensating expansion of the arteries there.

There was never any sign of gangrene of the toes. The tension of the limb remained for a year, and some swelling of the limb remains. He wears an A1 Martin rubber bandage, and leads

an active life, making no complaint about his limb.

At the time of the embolism he was kept in bed for three weeks, the limb being swathed in cotton wool. I sought to keep up the body temperature, of 98.4° only, around the limb, to allow no extreme of heat by hot jars, and the avoidance of winter cold.

The patient has pretty continuously taken caffeine and Oppenheimer's Glycero-phosphate Palatanoids, each holding  $\frac{1}{170}$  of a grain strychnine.

The patient's pulse now is about 75; heart's impulse of fair power; theirregular rhythm remains. He walks about with great comfort, and enjoys an hour or two light gardening daily.

I have interdicted all standing on steps to trim his over-head vines; he clunks—Eastern fashion—when gardening.

I remember a child, a year old, who having had, without known cause, one profuse stinking motion, collapsed to such a degree that embolism having happened during the collapse, several of its toes gangrened and came off. The diarrhoea, which continued after the primary onset, could not be arrested; the motions were stinking. I advised an egg-spoonful of lemon juice four times a day. In two days the child was well of the diarrhoea, and the fœtor was natural. This free use of lemon juice or lime juice I very largely practised in the chronic diarrhoea and dysenteric diarrhoea of the natives of India, and with the happiest results.

*On Reducing Fat.*—E. S., æt. 19, came in June, 1903; she weighed 197 lbs. She had taken for nearly a year, thyroid extract and Blaud's pills, but without benefit. The menses had been absent a year.

It was obvious that the thyroid had not balanced the correlations of her functions and system. I could make but a guess, in this orderly, obscure, and profoundly deficient correlation. I thus continued the Blaud's pills, also I kept the bowels fairly regular by Pil. Aloes et Fer., and for the system's general healthy metabolism I ordered the juice of two lemons a week.

But I had read somewhere of benefit following the use of thymus gland; so in place of thyroid I gave thymus extract. At somewhat regular intervals since June, 1903, her weight has been 197, 190, 189, 182, 174, 171, 167½, 170, 168, 162 lbs., a gradually ~~occurring~~ decrease of 35 lbs. in ten months.

Her menses were absent for two years, up to January, 1904; they appeared once, and have again ceased.

The gradual decrease of weight seems to indicate that the thymus may have had some influence for good. The girl's whole mental condition has improved, and she is equal to the duties of active domestic service.

One need not enlarge on the profound and complex, yet orderly, correlations of the structures and functions of the system; but we can always go a long way toward balancing these active energies and functions by attention to the *primæ viæ*, the great organic tract; the daily action of the bowels, established slowly and the habit formed, influences for good the whole system; every function is promoted toward harmonious correlation by the just activity and action of the great organic tract.

Disease, one may say, is grandly *general*;

secondarily, local. This truth is recalled to memory on a view of the prospectus, lately circulated, of the vast list and nomenclature of "different" diseases of the skin!

But the principle was vividly forced on me forty-five years ago and after, when I saw the night blindness, the anæmic cardiac bruits, the ulcerations of the legs, the ulcerative dysenteric diarrhoea, and other malconditions of the natives of India disappear, after the free use of "acid fruits"—lime juice, tamarind, &c.

The *general* nature of disease is most strongly and continuously forced on my attention here, in the great stream of præphthisis and phthisis which passes before me. For years even, before phthisis exists in the lungs, the young people will, in different cases, suffer from a sense of "weakness," or sense of coldness, or indigestion, or disturbed menstrual function, or failure of appetite; and these præphthisical symptoms, variously mingled in different cases, will be correlated to certain well-defined physical types of the bone system—such as large hands, large clavicles, unduly large terminal cartilages of the nose, which are often markedly unsymmetrical on the two sides; or the physical type of the præphthisical is often seen in abundant coarse hair, heavy eyebrows which meet in the mesial line, transverse ridges of the nails; so that, in my experience and recorded observations, the final lung disease is quite a minor part of phthisis, phthisis being a most *general* condition.

I could hardly avoid drawing these illustrations from East Indian diseases, and from European phthisis, of the general character of some of our seemingly most demarked diseases, as suggestive of caution in affirming the "cause" of E. S.'s fatness, and no less as suggestive of caution in affirming the "cause" of her recovery.

One would not dare to affirm that the thymus led to this girl's improvement; she was treated on wide general principles, but the thymus may have justly co-ordinated her inharmonious correlations.

*Slow Progress of Phthisis.*—It is within the knowledge of all practitioners that cases of phthisis have a most varying duration. One sees the bright young girl or youth carried off in a few months, and one no less sees cases running on for years, even to past middle age. It is impossible to state absolutely, the differences of the associated or correlating deviations of structure or function, which belong to, and precede, such different types of cases. Try as one will, it is impossible to state any single or group of differences, either in structure or function, which belong exclusively to either group; and yet the experienced and observant practitioner may often predicate aright, which cases will be rapid and which will be slow in progress.

Of the roses which bloom over the portico, some will fade and die earlier than others; and in young people, the same facts are seen. All may have the bacillus—yet some will rapidly succumb, others will survive for years.

The basis, or greater nature of phthisis, is deep down in the potential and kinetic "energies," and ultimate modes and motions of bioplasm—modes, motions, and ultimate attractions which are of cosmic range and infinite delicacy yet power, and which correlate both with structure



and function, atavically and alternately, often through many generations. Hardly a week passes but that I see the far-back and wide correlations of phthisis, both of structure and function, and I see also their atavism and alternation.

The phenomena are thrust on my observation; I am compelled to state them. I am compelled to see pathology as an orderly series of deviations of the infinite, eternal, and cosmic biological evolution, and as having no less wide correlations in the system.

And as Herschel says, "... a principle may be as completely and as plainly elucidated by the most familiar and simple fact as by the most imposing and uncommon phenomenon," I will cite but three cases in which bacilli were present, and in which the cases were of long duration. This long duration *à fortiori* illustrates how very near to absolute immunity were the patients. One of the cases further illustrates how the patient, ill in phthisis for twenty years, with bacilli known for the past four years, still survives as a bright active woman, whilst in the meantime she has lost two daughters—one at 12 years of age, the other at 20, of phthisis. Where is the potential condition which saves the mother? We must lift our mental view above and beyond the bacillus; we must give up the false but captivating rest in "single causes," in pathology; we must "stoop to conquer," have "humility of pretension," and see biology and pathology in their cosmic relations. Empiricism and the simple observation of Nature may lead us on a right path, long before Science has revealed the exact details.

E. H., female, *æt.* 50, a bright little woman, slight and active; hair wavy and coarse; nose rather pointed; for fifteen years past has had *râles*, and impaired resonance on percussion in the left infra-clavicular region; has had occasional *râles* in right infra-clavicular region. Tubercle bacilli are found. She is thin, but full of life and spirit. One daughter, *æt.* 12, and one, *æt.* 20, have, in the same period, died of phthisis.

The physical signs in her lungs have not progressed during fifteen years. How does her lung-apex bioplasm resist the molecular attractions of the uncelled bacillus? And how did that of her two daughters succumb? I am forced into view of a region of biology and pathology more general and deeper than that mainly confined to the bacillus. We are carried into the presence of "energies," modes of motion, and attractions, absolutely infinite in their correlations, delicacy, and power; the highest physics and vito-physics are involved.

I encouraged, in this case, fresh air; I encouraged her individual psychological tendencies and tastes, also allowed her what food she desired, what her bioplasmic-cell "unconscious memory" longed for, *e.g.*, the allyl modes and motions of the onion.

But the same efforts did not save her two daughters—How not? With her age, the cell-activities and inter-cellular bioplasmic attractions and bonds had, in the processes of the orderly evolution, become stable.

Viewing the phenomena of this mother and her two daughters, one can only say, with Goethe, "Thus, the whole of the throng points to deep-hidden law, points at a sacred riddle!" But bacillus is not the key to that riddle!

A. H., female, *æt.* 34, single, had severe pleurisy of the right side seven years ago. The physical signs of the pleurisy slowly, during two years, cleared off, but bronchial-like moist *râles* were ever present in the right lung. She gradually developed, during three years, well-marked phthisis of the right lung; and during the past year, in a less degree, of the left apex. She has, during the past year, begun to waste, the appetite has failed, and amenorrhœa has existed during the same period.

A. H. has worked up to six months ago in the active duties of a country inn, and has always done her duties well; has lived well. She is a woman of beautiful physical proportions, fine features, beautiful and sound teeth; her bone system is exquisitely fine, such as small, delicately-formed wrists. Tubercle bacilli are found in her sputum. Her system has held on long—six to seven years, but not so successfully as that of E. H., *æt.* 50.

J. M., male, *æt.* 50, came to me for shortness of breath and cough at night. I found slight impairment of resonance on percussion over the left apex, with a few moist *râles*. Tubercle bacilli existed in his sputum. He had lived very much an out-of-door active life, in a most healthy region of West Dartmoor; had drunk malt liquors and spirits freely and habitually. His nails were rather clubbed. Fourteen years ago he "took a chill," and has had cough ever since. Six months ago he took "another chill"; since then, his cough has been worse.

Here, again, as in the two former cases, is slow evolution of the disease, or, as better expressed, there exist "strong molecular bonds" in his lung-apex bioplasm, coincident with, and in correlation with, his age and his entire general system.

For it cannot be too strongly stated that in the widest use of that word phthisis is a *general* condition, and that its major form is *not* in the bacillus.

## MEDICAL ACTS AMENDMENT.

By GEORGE C. CRICHTON, M.D.

It has for some time been proposed to reform the General Council—to amend the Medical Acts.

The amendment on which *at present* most stress is laid is—Increase in the numbers of the direct representatives. Not much is to be hoped for from this, which is to be regarded not as a reform in itself so much as a means to bring about reforms. But which of these is possible in a Council whose only function is examinations, and every ten years a Pharmacopœia? The choice of the constituencies will fall upon the respectable middle-aged or elderly successful doctors; wise and experienced, no doubt, but not greatly daring. How many club doctors, East End doctors—two shillings, or shilling, or so much a week? If one looks through the journals for the last twenty or thirty years, as I have done, one finds repeatedly the accusation that the Council do very little but talk very much. If twenty general practitioners, besides, get on the Council, the effect must be disastrous to business being completed, for what is the use of their being elected if they do not express their views? So that one hesitates as to the value of this reform. When I looked in upon the representative meeting at Oxford, I could not but be struck with the seniority

of the members. Capable and alert, no doubt, otherwise they would not have attained their position there. One stood up, said two sentences, and sat down; then another said a sentence or two, and every second or third speaker proposed an amendment to another amendment to a motion. I soon got lost, and hopelessly. The chairman, however, arranged it all in his mind, and kept all the threads of the debate so completely in hand that he gave his decision when called for clearly and promptly. He looked the youngest of them all, and he is hardly a chicken. As I stood and looked on I saw the *machine* working—smoothly, steadily; but the absence of the note of boyhood touched me as something just a little pathetic. A large infusion of the general practitioner into the Council will, I think, hardly do.

With regard to other reforms, such as registration and finance, the question should at once arise whether every detail should be fixed by Act of Parliament or whether general instructions should be laid down and large powers given to the General Council to make whatsoever arrangements might prove to be the best from time to time? Other reforms, death certificates, foreign and Colonial diplomas, &c., have long waited for settlement. What more reasonable than to empower a duly constituted Medical Council to settle these? Of course, under supervision by a Secretary of State. An annual grant towards the Council's expenses would afford to Parliament an opportunity of discussion, so keeping the Council in touch with the community and Parliament acquainted with the fresh currents of medical knowledge. But this aspect of the case is too large for a short paper.

#### A NEW COUNCIL.

Let us imagine a convulsion of Nature to occur and Parliament to pass an Act reforming the General Council. We should expect that its functions and duties would be *everything* concerning public health, and that it would be in constant communication with the Government of the day as a consultative or advisory committee. It would have the power to issue decrees having the force of law, after obtaining the sanction of Parliament, in the same way as, I believe, the Board of Agriculture and the Board of Education. Practically it would constitute a standing *Committee of Public Safety in Time of Peace*.

It would necessarily be representative.

First. In the first place, instead of being a Committee of Examiners, appointed by every examining board in the Kingdom, there would be representation given to educational authorities, which are, however, also examining boards. It would be the chief business of the Council to supervise education, upon which depends admission to the *Register*, examination being only a test of efficient education. The Universities, then, will each select one representative. (For the present, the new universities in the Midlands, with Durham, would be grouped.) This would give ten or eleven members. It should be decided by the Bill whether the Senatus, as at present, or the General Council (Convocation) of the Universities (as for the representative in Parliament) should elect. The great London medical schools would have a member, elected probably by the staffs of the twelve hospitals. Perhaps the managing committees of these hospitals should elect one of themselves in addition.

Secondly, Direct Representatives. — Every man or woman on the *Register* should have one vote, and the votes should be as nearly as possible of equal value. This is only possible by division into electoral areas or provinces. In England, North, Middle, South, County of London, Wales and Monmouth (5); in Scotland, North-west and South-east (2); in Ireland, North and South (2); in all, 9 members. It is a debatable question whether the corporations should be represented. In a very special and real sense they do represent the profession. They might send three representatives. In England, *e.g.*, the Presidents of the Colleges and the Master of the Apothecaries would in turn elect one member to sit for three years.

The medical element of the Council is now complete. If, however, it is to have large administrative and consultative powers, the general public will be represented. The only practicable way in which this can be accomplished is, I fear, by giving another third of the representation to the President of Council, or other Cabinet Minister. It would be for him annually to appoint two members to serve for five years, ten in all. The Crown members would thus (1) be attached to no political party, and (2) on the occasion of any new question cropping up there would automatically be two vacant places for experts to be appointed to. These appointments should be not as heretofore filled up by fashionable Court physicians and surgeons, but a country doctor, an Army doctor, if you will, but non-medicals chiefly, a barrister or two, some City merchants, perhaps a bishop. A too narrow professional tone should be shunned. Finally, as already said, a grant from the Exchequer would give to Parliament a yearly opportunity of reviewing the proceedings of what would be then, and for the first time, a *General Medical Council*.

Its representatives would consist of:—

- |                      |                   |
|----------------------|-------------------|
| 1. Universities, &c. | 11 to 13 members. |
| 2. Professional ..   | 9 to 12 ..        |
| 3. Government ..     | 10 to 10 ..       |

*i.e.*, from .. 30 to 35 members.

The exact constitution of the Council will obviously depend entirely on its duties, and the purpose for which it is called into existence. Representation *implies* Devolution.

## PULMONARY EMBOLISM,

PROBABLY FOLLOWING THROMBOSIS OF THE HÆMORRHOIDAL VEINS.

By ALFRED S. GUBB, M.D. Paris, M.R.C.S., &c.,  
Of Aix-les-Bains and Algiers.

INSTANCES of pulmonary embolism are sufficiently rare in general practice to render diagnosis a matter of considerable difficulty, especially in the absence of phlebitis or other morbid condition to put the practitioner on his guard. Moreover, in many cases the symptoms at the onset are so vague and ill-defined and withal, so violent that relief of suffering is apt to occupy one's whole attention to the exclusion of pathological problems. Even if one reads up the literature of the subject in the light of a recent case one obtains but little assistance. The various kinds of emboli are duly classified, and they are traced—in the *post-mortem* room—into the ultimate ramifications of the pulmonary artery if indeed their dimensions do not happen to be such as to have caused them to become impacted in one or other of the larger branches. When we turn to the symptomatology one finds nothing absolutely distinctive:

in fact, I am fain to think that in the majority of instances the diagnosis can only be a matter of surmise until the case has run on to its logical conclusion. This being so, a few brief notes of a case that recently came under my notice at Aix-les-Bains may not be devoid of interest.

The patient was an elderly gentleman, a patient of Dr. Cazalis. He had been operated upon a month previously for the removal of troublesome rectal prolapse. Matters had progressed favourably, and at the end of a month the wound had soundly healed and he was authorised to travel to Aix, but he was directed to make daily use of a bougie to overcome any tendency to cicatricial contraction. He had no varicose veins, and was in every respect in perfect health. He took a few baths and felt so well that he was on the point of leaving for his distant home when suddenly, one afternoon, he was seized with intense pain, with a feeling of constriction in the left side of the chest, more marked in front, the pain radiating down the left arm as far as the fingers. The pulse was rapid and the breathing shallow and somewhat gasping. At first sight it looked like a typical case of angina pectoris, and a dose of ether, followed by the hypodermic injection of morphine, afforded a great measure of relief. The dyspnoea, however, persisted on the following day and on auscultation a patch of fine rales was made out just to the left of the sternum, behind the fourth and fifth costal cartilages. The pulse was still rapid and small, the heart sounds were distant and muffled, and they were masked by the rales, which were attributed to pericardial friction. The temperature was normal. The tongue was very thickly furred and there was complete anorexia with occasional attacks of nausea, and even actual vomiting after taking food.

In view of the intensity and obscurity of the symptoms the patient was kept under close observation, and it was at this juncture that Dr. Cazalis asked me to assist him in the management of the case. A blister was applied over the base of the heart, followed by poultices, with occasional injections of morphia, but although we were successful in relieving the pain and dyspnoea to some extent, the patient's condition in no wise improved. On the morning of the second day after the onset of the attack dulness and crepitation appeared in the front of the right lung, and on the following day, April 26th, the patient, who so far had not been troubled by cough, began to expectorate sputum containing bright red blood, frothy and mixed with viscid mucus. There was nowhere any bronchial breathing and the temperature remained normal. On reviewing the symptoms we came to the conclusion that it was probably a case of pulmonary embolism, although we were at a loss to account for its occurrence, the possibility of its having any etiological connection with the operation on the rectum six weeks previously appearing rather remote.

Advantage was taken of the presence in Aix of Professor Chantemesse, of Paris, to obtain the benefit of his experience. He confirmed the view that the case was probably one of pulmonary embolism, presenting the unusual feature that the left lung was the first to be involved. In the absence of any other plausible explanation of the origin of the embolism he was inclined to incriminate a thrombosis of the hæmorrhoidal veins, consecutive to the operation. Possibly the introduction of the bougie had displaced part of the clot, which had thus found its way into the circulation. Inasmuch as clots in that situation would in all probability be infected, he took a grave view of the case.

The congestion, with the accompanying rales in the left lung in front, interfered greatly with auscultation of the heart, but the small, rapid and sometimes unequal pulse testified to the existence of profound cardiac disturbance. Digitalin (Nativelle) was prescribed for the purpose of reinforcing cardiac action, but the result did not fulfil our expectations.

During the next few days the patient's condition varied, there were temporary improvements followed by fresh outbursts of congestion, both in front and at the bases, and increased dyspnoea, and on each occasion the

sputum which, from bright red had become rusty, again contained fresh blood. The temperature oscillated about normal, and the pulse, rapid and small, varied between 110 and 130 per minute.

On the tenth day of the illness the urine became scanty and contained a trace of albumin. The patient became subject to violent attacks of spasmodic dyspnoea, which distressed him greatly, especially at night. These attacks presented a close resemblance to asthma, and were assuaged by morphine, dry and wet cupping and stramonium inhalations. In the course of the next few days the urinary secretion fell to about a pint in the twenty-four hours, in fact, it was obvious that the pulmonary condition was complicated by uræmia. The pulse became very weak and at times almost imperceptible, and at intervals copious cold sweats broke out. He rallied for a time under injections of spartein and caffeine, but his speech soon became incoherent and he lapsed into a state of coma, in which he died in spite of inhalations of oxygen and stimulants.

No *post-mortem* examination was obtainable, but the history of the case, the repeated formation of rounded areas of pulmonary congestion, the expectoration of bright red and then brown sputum, followed by further expectoration of bright blood consequent upon fresh areas of congestion, the absence of marked febrile reaction, and finally the toxic uræmia that closed the scene all point to pulmonary embolism as the result of a disintegrating clot somewhere in the venous system, the source of the mischief being in all probability in the hæmorrhoidal veins.

## Transactions of Societies.

### CLINICAL SOCIETY OF LONDON.

MEETING HELD DECEMBER 9TH, 1904.

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

#### THE TREATMENT OF INTUSSUSCEPTION IN CHILDREN.

MR. CUTHBERT S. WALLACE read a paper on a series of cases of intussusceptions in children treated at St. Thomas's Hospital and the East London Hospital for Children between the years 1898 and 1904. There were 20 cases in all, the ages varying between three months and thirty-three months. There were 12 males and 8 females. Of the twenty cases 19 involved both the small and the large gut; the remaining case was one of the colic variety. Eleven were single tumours and 9 were double. The author agreed with Mr. Edred M. Corner that the double tumours were more common than supposed, and he referred to the difficulty that was encountered if a complete nomenclatural classification were attempted. The diagnosis was clinched by the finding of a tumour, and if there were any doubt of the presence of a tumour an anæsthetic should be given and the matter settled at once. The treatment was primary celiotomy, the most convenient incision being through the right rectus beside the umbilicus. The author did not lay any great stress on the reduction of the tumour within the abdomen, but thought that time was the most important element in the treatment. The after history of the cases seemed to show that as far as the ultimate result was concerned the method of suture of the belly wall was immaterial. The method favoured was by deep sutures through the whole thickness, and buried sutures through the sheath of the anterior rectus. By this method the danger of the incision coming open from failure of union was reduced as far as possible. Of the twenty cases four died, giving a case mortality of 20 per cent. If the two cases of resection were excluded the case mortality fell to 11.11 per cent. The author finally referred to the great fall in the case mortality that had taken place of late years. Statistics drawn from the records of St. Thomas's Hospital showed that there was a marked increase in the number of cases of intussusception admitted to hospital.

#### ON THE TREATMENT OF INTUSSUSCEPTION IN CHILDREN BY LAPAROTOMY.

Mr. C. H. FAGGE read a paper based on the results of

18 laparotomies, of which 17 were primary and one was undertaken after two attempts at reduction by inflation had failed. In 16 a tumour was discovered either in the abdomen or *per rectum*; both the other two cases ended fatally; in the first no surgeon was called in for twenty-four hours and though reduction was easy, the patient, *æt.* 9, died on the fourth day; in the second, a boy, *æt.* 15, the intussusception of the enteric type, was irreducible, and was resected. He drew attention to the variable position occupied by the tumour and insisted on the importance of routine rectal and bimanual examination, if necessary under an anæsthetic, as aids in coming to a prompt diagnosis. Duration before operation varied from five hours to three weeks, and though there was no direct relation between this and ease of reducibility, he pointed out that no case in which the duration was less than forty-eight hours had been irreducible. Eleven were single and seven double intussusceptions, of which at least 10 were ileo-cæcal, and 3 colic ileo-cæcal; he did not regard a minute division of intussusceptions as of much clinical value; probably 8 of his cases would not have been, owing to their origin above the ileo-cæcal valve, in any way affected by inflation or irrigation. Reduction was by laparotomy, carried out with all possible speed through an incision usually in the right semilunar line, and this was aided if necessary by an assistant's finger in the rectum, which reduced the intussusception well into the descending colon. Five cases were irreducible and all were fatal; in one an artificial anus was formed, and in all the others resection was performed and the ends of the bowel united, in one by Maunsell's method, and in the other three by simple end-to-end anastomosis with two rows of sutures, the inner passing through all the coats and the outer through the muscular and peritoneal coats. Of the 18 cases 7 died, giving a mortality of 39 per cent.; of the reducible cases (13 in all) 2 died, a mortality of 15.4 per cent.; in the 14 cases under one year the mortality was 21.4 per cent., or, excluding the two which were irreducible, there was only one death, giving a mortality of 8.3 per cent.

Mr. ARTHUR BARKER remarked on the large number of double intussusceptions recorded by the authors. He had never seen a case of this nature, although he had operated on over thirty cases. He agreed with Mr. Fagge that escape of the bowel from the abdomen was a most undesirable complication of the operation, as it lengthened the time occupied, and added to the shock. He differed from both authors as to the length of incision necessary, and thought it was rarely advisable to make one over two inches long. He attributed the cases just described of bursting open of the wound to this factor, as he has never seen such an occurrence in his cases. In this connection he believed it was important to conduct the first dressing under opium and chloroform. He was very interested in the question of toxæmia, and had several times noted a rise of temperature on the following day to 105° F., and even to 107°, there being no diarrhoea, distension, or other symptom. He was very pessimistic about the gangrenous cases, as he had never had recovery after resection in such cases, and never expected to see one. The only hope lay in earlier operation.

Dr. CHAS. BOX referred to the medical aspect of the subject and upheld the custom of admitting all acute abdominal cases first under a physician. He believed that the danger of a double administration of chloroform, first for diagnostic purposes and then for treatment, was counterbalanced by the gain in knowledge attained when dealing with cases of doubtful enteritis with melæna. He discussed the diagnosis and mentioned a case of Riedel's lobe of the liver, thought to be of congenital origin, which gave rise to difficulty. He did not think that any additional shock arose from the escape of intestines from the wound, while this was often an indispensable aid to the operator. He considered that the occasional bursting open of the wound resulted from non-union, due to toxæmia, and instanced the analogous cases of non-union after operation on perforated typhoid ulcers.

Mr. DOUGLAS DREW had operated on thirteen cases. Two gangrenous cases died, and one other. This latter had a temperature of 106° on the following day, and died of toxæmia. This case was one of double intussusception, the only one he had ever seen. He, like Mr. Barker, reduced within the abdomen, but always withdrew the cæcum so as to examine it. In several of his cases the caput coli was the most difficult position to reduce. He had never seen a wound burst open.

Dr. BROOK asked whether inflation was ever justifiable. He had performed it with success. He also would like to know what treatment Mr. Wallace recommended for the irreducible cases, whether splitting of the outer layer or resection.

Mr. WALTER SPENCER speculated as to the cause of the toxæmia. It might arise from the intestinal lumen from the strangulated vessels, or from the peritoneal cavity. Could anything be done for the condition, say by stimulating peritoneal phagocytosis?

Mr. JAMES BERRY had seen forty or fifty cases operated on. He had never heard of a successful resection under the age of two, and doubted its justifiability. That being so, it was correct to use force in persisting in the attempt to reduce difficult cases.

Mr. MCGAVIN asked how often relapses occurred after laparotomy, as compared with relapses after inflation.

Dr. TAYLOR pleaded guilty to having assisted at inflation, and had even recorded successful cases before this Society.

Mr. WALLACE, in reply, said that his unusual number of double intussusceptions was probably due to chance, though it had been suggested that many such cases dealt with intra-abdominally were overlooked. The length of incision was a personal preference, it being impossible for some operators to work through a small orifice. He was convinced that the bursting open of wounds was not due to long incisions, as it occurred when these were only one inch long, but was probably due to toxæmia. He thought that inflation should never be done, as no one could ever tell whether complete reduction had taken place, the disappearance of the tumour might only mean that the intussusception was tucked away behind a flexure or under the liver. He, like Mr. Berry, had never heard of a case of successful resection under the age of two, so that forcible manipulation was the only thing to do. In certain cases, such as those with a prolapse of the ileum through the ileo-cæcal valve, actual pulling was indicated as well as the usual pushing and squeezing. He had never seen a recurrence after operation.

Mr. FAGGE, in reply, also thought that double intussusceptions were often missed, but, as laparotomy was always indicated, their importance need not be insisted on. He never made an incision under three inches long, even in a small child. He regarded the onset of toxæmic symptoms, such as a temperature of 103° or 104°, as of favourable import. He had only seen one case of recurrence after operation, but many after inflation.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF SURGERY.

MEETING HELD IN THE ROYAL COLLEGE OF SURGEONS  
ON FRIDAY, DECEMBER 2ND.

The President, Mr. ARTHUR CHANCE, in the Chair.

#### EXHIBITS.

Mr. R. C. B. MAUNSELL exhibited a child after operation for spina bifida, also the meningocele which he had removed.

Mr. KENNEDY exhibited (a) Infant operated on for intussusception; and (b) child treated for hydrocephalus by repeated lumbar puncture.

Mr. BLAYNEY exhibited a Gasserian ganglion removed for epileptiform neuralgia.

Mr. W. TAYLOR exhibited (a) Gall-bladder removed

for gangrenous cholecystitis; and (b) hydronephrotic kidney.

Mr. EDWARD H. TAYLOR read a paper entitled **A NEW METHOD OF PROCEDURE FOR THE RADICAL CURE OF INGUINAL AND FEMORAL HERNIÆ**, and illustrated its various stages by means of lantern slides. Having introduced the subject by some general remarks concerning the anatomy of the inguinal canal and the aims of herniotomy, he proceeded to explain his method of operation. With the patient in the Trendelenberg position, a vertical incision about four inches in length is made midway between the middle line and the outer border of the rectus muscle in its lower part. The superficial tissues and the rectus sheath having been divided, the outer lip of the divided sheath is raised and the corresponding border of the muscle defined and drawn inwards. The transversalis fascia is then divided and the extraperitoneal fat exposed. The next step consists in fully retracting the outer margin of the wound towards Poupart's ligament, and identifying the neck of the hernia. By seizing the parietal peritoneum close up to the internal abdominal ring with the finger and thumb, the sac is drawn up to some extent out of the inguinal canal and opened, after which a finger is introduced into its interior to act as a guide while it is being separated from the structures of the cord. A ligature or purse-string suture is then applied to the neck of the sac, and the fundus cut away. The inguinal canal and the two rings are now explored by the finger, the structures of the cord are identified, and the deep epigastric vessels held aside. By means of special needles in handles—modifications of the ordinary aneurysm needle with a slot at one side opening into the eye—a series of silk sutures (No. 6 size) are passed so as to connect the conjoined tendon and the transversalis muscle with Poupart's ligament, just enough space being left to allow the structures of the cord to pass without being unduly compressed. The rectus muscle now resumes its normal position, but for greater security its outer border is connected to the deep aspect of the transversalis muscle by a few interrupted sutures. Finally, the rectus sheath is closed in front by interrupted sutures also, and the skin margins approximated by a continuous subcuticular suture of silkworm-gut. Should the external abdominal ring be unduly patulous it may be readily exposed before closing the wound by drawing aside or reflecting the overlying tissues, and its dimensions reduced by one or two sutures. In the case of femoral hernia the steps of the operation corresponded to the above up to the point at which the femoral ring is exposed. The sac is isolated as already described, ligatured at its neck, and its fundus cut away. The closure of the femoral ring is then effected. Two sutures generally suffice for this purpose. Each passes through the conjoined tendon and Poupart's ligament in front, beneath Cooper's ligament behind. In some cases it is advisable to pass them through two holes previously drilled in the pubic bone. Mr. Taylor pointed out that a somewhat similar method for occluding the femoral ring had been described by Mr. Mayo Robson in the "Year-Book of Treatment" (1904), but, nevertheless, it differed from his in certain important particulars.

Mr. JAMESON JOHNSTON expressed himself in favour of Bassini's operation, as he considered it the simplest, most scientific, and the easiest. He regarded the objection to dividing the aponeurosis of the external oblique in this operation as more or less theoretical. Mr. Taylor's operation would probably be a good one in old herniæ, in which the internal abdominal ring approached the middle line.

Mr. T. E. GORDON considered there was no one method of operation for hernia. Mr. Taylor's method was not suitable in the case of a congenital hernia in a young child. He believed there were many of the operations practised which were hopeful as regarded ultimate success. The essential thing in these operations was asepsis.

Sir THOMAS MYLES referred to the valve-like nature of the inguinal canal. So long as its anterior and

posterior walls remained in contact and the muscles sufficiently tense a hernia was unable to push these walls apart. He thought there was a hereditary predisposition to hernia. The valve-like closure of the canal, due to muscular action, was essential, and that being so, no amount of suturing of the conjoined tendon to Poupart's ligament would provide an obstacle to recurrence, because sufficient space had to be left to permit the cord to pass.

Mr. BLAYNEY was of opinion that the weakness of the abdominal wall in the inguinal region was for a special purpose, *vis.*, to allow the thin fascia transversalis being pushed against the external oblique when the intra-abdominal pressure was increased.

Mr. TAYLOR, in reply, stated that he believed his method of operation was best suited for large, well-developed inguinal herniæ, in which the inguinal canal had undergone marked changes in size and direction. As bearing upon the success of the procedure he thought it of importance to mention that the sutures in the conjoined tendon should not be tied too tightly, and that the parts should be kept at rest for a sufficient time afterwards to permit of healing taking place. Patients were frequently allowed to get about too soon after herniotomy; absolute rest for at least a fortnight was desirable. As to the mode of development of an inguinal hernia, he thought it probable that there was in many instances a degree of congenital weakness at the internal abdominal ring, in consequence of which the latter went on increasing in size. There was such a thing as a hernial type of abdomen, and it was in such cases that weakness or dilatation at the internal abdominal ring was most likely to be found. Upon the hernia commencing to develop, the conjoined tendon and the fascia transversalis yielded more and more, and the inguinal passage became progressively larger, and less oblique in its direction.

Mr. T. E. GORDON read an account of a case of ACUTE INTESTINAL OBSTRUCTION FROM A GALL-STONE.

The patient, æt. 73, had had an attack of biliary colic in February, and she did not recover fully from this for two months. On August 6th, she was seized with intense pain in the liver region, and this was followed by complete obstruction of the bowels. Three stages in the course of the illness were clearly defined: (1) A stage of onset lasting from August 6th to August 7th, marked by intense epigastric pain and vomiting, but without fever; (2) a stage of quiescence lasting until August 9th; (3) a stage with unequivocal signs of intestinal obstruction. The operation was performed by Mr. Gordon on August 11th. A gall-stone was found firmly impacted in the upper part of the jejunum. After the operation all vomiting ceased, and the patient was able to leave her bed in about a fortnight. Mr. Gordon, in attempting to interpret the clinical signs, said he thought it probable that impaction did not occur prior to the third stage. It was difficult to understand why a stone of such small size should cause intestinal obstruction. Spasm was obviously an important factor.

Mr. W. TAYLOR stated that he had seen the patient a few days before Mr. Gordon performed the operation and on the day before he left town for his holiday. She was then under the influence of opium. He thought that at that time, the gall-stone made its exit from the bile passages. At the same time, however, he had not overlooked the possibility of intestinal obstruction. He would like to know if any reasonable explanation could be offered why a calculus of this size should become impacted.

Sir THOMAS MYLES alluded to a case in which he had removed a large impacted gall-stone, fifteen years ago. He thought it likely that the impaction in the present case was due to the opium administered, the muscular tissue of the bowel being paralysed. He would advise in such cases that the incision into the intestine be made not directly over the gall-stone, but on the proximal side, as otherwise one cut through infiltrated and devitalised tissues.

Mr. JAMESON JOHNSTON inquired as to the amount of distension present and the condition of the bowel

at the site of impaction. Mr. Gordon alluded to spasm but he did not think spasm could exist under the conditions present, *viz.*, inflammatory infiltration and oedema of the bowel wall.

Mr. BLAYNEY thought the impaction of the gall-stone in the present case might be due to its rough exterior, by which the mucous membrane of the intestine was irritated and abraded, thus permitting micro-organisms to act. This resulted in oedema of the sub-mucous tissue which extended inwards rather than outwards. He believed the impaction was due more to inflammatory oedema than to spasm.

Mr. GORDON, in reply, said he thought some of the suggestions which had been made as to the cause of the impaction were correct, but that he himself had none to offer. The abdominal distension was not very great. He made the parietal incision above the umbilicus, because the early pain complained of was referred to the upper part of the abdomen.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD DECEMBER 1ST, 1904.

DR. JAMES BARR, the President, in the Chair.

DR. GROSSMANN showed a patient with Conical Cornea, and demonstrated the skiascopic appearances, which were particularly striking in this case owing to the high degree of the deformity, its centrally situated apex, its complete transparency, and the easy comparison with the other unaffected eye.

Dr. W. B. WARRINGTON read a note on the Plantar Reflexes. He described the plantar reflex of the normal flexor type and the pathological extensor response. He emphasised the importance in the method adopted for obtaining it, and considered that only to the slow, deliberate extension could a certain pathological significance be attached, though other types of extension might be very significant. The reflex obtained in various diseases of the nervous system was described, and it was maintained that the character of the reflex was a valuable aid in distinguishing between functional and organic disease, and equally so in differentiating between the different kinds of organic nervous disease.

Dr. T. R. Glynn, Dr. R. J. M. Buchanan and Dr. J. Hill Abram took part in the discussion.

Dr. W. ALEXANDER exhibited a Dumb-bell Calculus he had removed from a man, *æt.* 43. The calculus had existed for some years, and a rigorous administration of solvents had no influence upon it. Suprapubic lithotomy was performed, a stone removed, and the wound closed. It was then found that another stone remained behind the prostate; this was removed by median lithotomy. The two stones thus removed formed a dumb-bell calculus. The bladder was divided into two cavities with a constriction between. It was found impossible to distend the bladder with lotion preparatory to the suprapubic lithotomy, as when the small sac was filled contractions occurred and the urine was expelled with force alongside the catheter. Dr. Alexander said the case was unique in his experience, but Mr. Poland, in "Guy's Hospital Reports" for 1857, described a nearly similar case and discussed the mode of formation of such calculi.

Mr. RUSHTON PARKER said that the first perineal section performed by him, now many years ago, on a boy, *æt.* about 11, gave a dumb-bell calculus, one portion of which lay in a sac by the prostate, and the other in the bladder.

Dr. C. J. MACALISTER read a paper on "Some Thoughts and Suggestions Concerning Gastric Ulcer." He pointed out the fact that the characters of the ulcers are peculiar, both as to their shape, the course which they run, and their surroundings, and commented upon the unsatisfactory explanations which have been given heretofore concerning the cause of the disease. By a series of lantern slides he demonstrated the characters of the simple gastric ulcer in its uncomplicated condition, as distinguished from the same ulcer when secondary inflammations had taken place, and he also gave illustrations of other types of ulceration, and

pointed out that these did not tend to be converted into the so-called simple perforating ulcer. In seeking for a cause of the condition, it was obvious that the disease mainly attacked women; and from a study of the sequence of events connected with the development of the thyroid, the association of amenorrhœa and of concomitant indications of vaso-motor spasm, followed by the chlorosis and stomach disorder, he suggested that the disease was another instance of vaso-motor spasm followed by necrosis dependent upon a toxæmia. He thought this the more probable since the administration of thyroid extracts frequently relieved the amenorrhœa, and that following this there was sometimes great general improvement in the health of the patients. Dr. Macalister was emphatic concerning the necessity for taking the cases in hand during the early stages, and that whatever might be done in the way of thyroid treatment later in the disease, it was necessary to use all the usual precautions as regards rest, diet, and palliative treatment in addition.

The President, Dr. E. T. Davies, Mr. E. M. Stockdale, Dr. W. Carter, Dr. T. R. Glynn, Dr. T. R. Bradshaw, Dr. J. Hill Abram, Dr. E. E. Glynn, and Dr. R. J. Logan took part in the discussion.

A resolution congratulating Mr. E. R. Bickersteth on having attained his jubilee of membership was proposed by the President, seconded by Mr. Rushton Parker, and carried with acclamation.

#### LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD DECEMBER 3RD, 1904.

DR. LAW showed a case of incrustations in the trachea, which had been shown at the former meeting. The patient suffered from considerable dyspnoea, and the question was raised as to whether tracheotomy might not be necessary. Dr. Bronner showed some crusts from a case of dry catarrh of the nose and nasopharynx which had been treated by formalin spray. An interesting case of epithelioma of the larynx was shown by Sir Felix Semon. Thyrotomy had been performed but was followed by fairly rapid recurrence. Subsequently a great part of the affected half of the larynx was removed, and the man made an excellent recovery. The striking part of the case was the extraordinarily good voice left. An apparently almost unique case of a bony growth in the ethmoidal region of the nose in a girl was shown by Dr. Lambert Lack. There was obstruction of the maxillary osteum from the growth, and mucocele of the antrum. The diagnosis microscopically suggested was ossifying sarcoma. Two cases were shown of tumours in the neighbourhood of the tonsil; one by Dr. Wyatt Wingrave, in a female, *æt.* 64, and the second by Dr. Tilley, in a young man. In Dr. Tilley's case there were a large number of enlarged cervical glands, and in both cases the diagnosis was that of a lympho-sarcoma. In Dr. Tilley's case the glands and the enlargement of the tonsil had almost entirely disappeared under the influence of large doses of arsenic. An interesting case of chronic laryngitis in a man, *æt.* 32, was shown by Dr. Cathcart. The general opinion of members was that the condition was one of extreme pachydermia. Mr. F. J. Steward showed a case of complete paralysis of the left vocal cord, due to a tumour of the thyroid. The clinical aspects of the tumour were those of non-malignancy, but the case was shown with the view to eliciting opinions as to the question of malignancy.

#### ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST.  
DECEMBER 8TH, 1904.

DR. JOHN CAMPBELL, in the absence of the President, in the Chair.

THE following gentlemen were elected Fellows of the Society:—Drs. D. C. Kirkhope, S. Macauley, and J. H. Lowry, all of Belfast; and the following as Members: Drs. S. T. Irwin and S. Blakeley, of



Belfast ; J. M'Clatchey, of Dumurry ; and J. McArthur, of Grey Abbey.

Mr. ROBERT CAMPBELL, F.R.C.S., read a paper on SOME INJURIES TO JOINTS.

Dealing with those of the lower end of the humerus, he said that all fractures should be put up in the acutely flexed position, except those in which there was displacement of fragments of the bone. Fractures of the head of the radius he found most often as the result of bicycle accidents, the rider getting a side-slip and lighting on the palm of the hand. The fracture generally ran in an antero-posterior direction down the head of the bone, tailing off to the inner side. The fragment of bone was often broken into two pieces. The signs of this fracture might be slight : simply swelling and tenderness over the head, but on pronating and supinating the hand to an extreme degree one could get crepitus over the head. If such a fracture were left alone the callus would eventually interfere with movement, and the best treatment was to cut down on the head of the bone and remove it, the results being good. Fractures of the carpal bones were frequently seen in hospital as cases of "sprained wrist" that had never been treated, or which had not recovered under treatment. They showed thickening and tenderness over the carpus. These fractures were due to a fall, not a crush. The diagnosis could only be made by a careful palpation of each row of carpal bones ; tenderness will be found at both back and front of one bone. Radiography is most useful in confirming one's diagnosis in these cases. Fracture of the base of the first metacarpal bone is due to force applied to the end of the thumb, and is discovered by the tenderness on pressure in that direction. The diagnosis is difficult unless one gets a history of violence applied in this direction, and may only be possible by radiography. Dislocations of the semilunar cartilages of the knee-joint are often described as being outwards, but in the large number of cases which Mr. Campbell had seen in the Royal Victoria Hospital extern he had never seen one outwards. He had operated on seven, and in all but one the displaced cartilage was lying between the condyles of the femur. He considered the only really satisfactory treatment was removal. If his observation as to the direction of displacement was correct, it showed the absolute futility of all special pads and such things.

The paper was discussed by Drs. O'NEILL, FULLERTON, MITCHELL, MOORE, ST. GEORGE, and O'CONNELL, several of whom expressed strong dissent from the views set forth in the paper.

Mr. ANDREW FULLERTON, F.R.C.S.I., showed skiagrams of (a) fracture and dislocation of the astragalus, and (b) dislocation of the scaphoid and fracture of the carpal bones.

Mr. A. B. MITCHELL, F.R.C.S.I., read a paper on some INEFFICIENT GASTRIC OPERATIONS, giving an account of six operations in which the hoped-for relief had not been obtained, or had been only temporary. The paper was virtually a continuation of one read last session, giving an account of a large number of operations for the relief of gastric ulcer and the conditions arising therefrom. The paper was discussed by Messrs. Kirk, Fullerton, and Robert Campbell.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, December 12th, 1904.

### EPIGASTRIC PAIN IN NEURASTHENIA.

THIS symptom, common enough in general practice, is frequently misunderstood by the practitioner. It may be classed with the painful form of dyspepsia where there exists hyperæsthesia of the mucous membrane.

The patient is generally a woman. She complains of pain in the stomach coming on after eating. Sometimes a sensation of burning exists, with acid regur-

gitation. The case is supposed to be one of hyper-acidity of the stomach, which, in fact, often co-exists, but not constantly, or that of ulcer. The patient is ordered milk diet, absorbent powders, and warm drinks, but with no result ; the suffering continues. After a time the patient throws aside the régime and eats as usual, and is surprised to find that the food passes without any inconvenience, except spiced food and wine. M. Page published lately several cases where the above symptom was the most prominent, and came to the conclusion that such patients are of the neurasthenic class, in whom the epigastric pain is provoked by different causes—emotion, food, monthly periods, &c. The pain is very violent, and has two points of election : three fingers' breadth from the xiphoid cartilage in front and the eighth dorsal vertebra behind, and is due to neuralgia of the solar plexus. Certain organs, as the uterus and kidneys, being in the territory of this nerve system, should be examined with care, and by treating the affections of these organs (metritis, floating kidney, anteversion, &c.), the epigastric pain would be cured. But frequently no cause can be discovered.

M. Page recommends faradisation of the stomach.

### TREATMENT OF EXOPHTHALMIC GOITRE.

AMONG the agents employed in the treatment of exophthalmic goitre, there is one which was recommended some years ago by a provincial physician, and although others tried it with considerable success, that treatment has fallen more or less into oblivion. However, quite recently Dr. Joussemet took this subject for his thesis and published eighteen cases of exophthalmic goitre treated by this method, with unvaried success. M. Joussemet does not believe that every case is amenable to salicylate of soda. For him, it is the pure form, with or without goitre, with neuro-arthritis as predisposing cause, emotion for determining cause, and phenomena due to the functional hyper-activity of the cells of the sympathetic system for symptoms, that this agent acts almost as a specific.

The dose is generally fifteen grains three times a day, but larger doses may be given if well borne by the patient. To avoid irritating the stomach, however, it is good treatment to give it in milk or in Vichy water.

The treatment must be continued for weeks, months, and even a year, with a few days' interruption every month.

### TREATMENT OF SENILE GANGRENE.

The treatment varies according to the period of the disease. At the beginning, when the condition of the threatened region can be improved, recourse will be had to vaso-dilators or cardiac tonics, rest in bed with the limb bound in dry cotton wool to encourage the circulation in the affected parts, and as a therapeutic agent :

Iodide of potassium, 1 dr. ;

Water, 10 oz.

A tablespoonful twice a day.

At the same time theobromine, an admirable diuretic eliminating the toxins of the blood, and a cardiac tonic, will be given in the daily dose of ten grains.

After twenty days of this treatment, trinitrin will be ordered for the last ten days of the month :

Solution of trinitrin 1-100, 40 min. ;

Sulphate of spartein, 15 grs. ;

Water, 12 oz. ;

Three dessert-spoonfuls daily ;

or

Nitrite of soda, 30 grs. ;

Bicarb. of soda, 2½ drs. ;

Nitrate of potash, 2½ drs. ;

Water, 10 oz. ;

Three dessert-spoonfuls daily.

Once the gangrene has set in, the above treatment can be continued, and local antiseptic treatment instituted. According to Dr. Huchard, lotions with permanganate of potash solutions (1-1,000) followed by the permanent application of compresses wet with oxygen water, recently prepared, is the best. Some

patients, however, prefer the dry treatment. In such cases, after cleaning the parts with oxygen water, peroxide of zinc gauze is applied.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 10th, 1904.

At the last meeting of the Gesellschaft der Aertze Hr. Bumm spoke on  
LIGATURE OF THE EFFERENT UTERINE VESSELS FOR  
PYÆMIA.

Four years ago, Freund proposed ligature of the vessels going from the uterus in cases of pyæmia proceeding from that organ, as they frequently contained suppurating thrombi. Freund had had a recovery, but he had not. Trendelenberg ligatures the hypogastric veins without touching the spermatic in one case, and with a good result. The latter operation also led to a good result in the hands of Michaelis. The speaker now brought forward the two first cases of recovery from chronic pyæmia after ligature of the hypogastric veins. In the first case peritonitis set in soon after delivery; the patient recovered from this by drainage. Then rigors took place. He ligatured the spermatic before the hypogastric. The ligatures sufficed to completely arrest the circulation in the veins of the pelvis; double ligature and excision would only have given a fresh occasion to renewed infection. As the veins were still there after the operation there might still be a few rigors of no importance. In the second case, the pyæmia followed delivery by forceps. Whilst Trendelenberg operated extra-peritoneally, he proposed to operate from the peritoneum, as the desired result was obtained more quickly. One must bear in mind not to ligature the ureter, which ran near to the vein.

Hr. Stoeckel related a case of  
GANGRENOUS CYSTITIS

in a woman (with cystoscopic demonstration). In a case of sepsis following forceps delivery, recovery was delayed by an attack of gangrenous cystitis. Such a cystitis might cause a patchy or a more extensive superficial destruction of the bladder wall. The pain accompanying the affection resembled that of labour. The destruction was not total, as was formerly believed, so that attachments to bowels helped to form a container for the urine, but the bladder was retained *in toto*, the shelled-off part only reaching to the middle muscular layer, the part where the circular muscles lay around the orifices of the ureters. The result was insufficiency of all the openings, through loss of the controlling muscles. Thus in the case before them (demonstration) the openings of the ureters were not small flat slits, but crater-like, gaping depressions. This loss of closing power was the cause of the increased danger of ascending suppuration.

At the Society für innere Medizin, Hr. Senator spoke on

PHYSIOLOGICAL AND PATHOLOGICAL ALBUMINURIA.

Up to modern times, albumin in the urine was always looked upon as pathological. He himself, in 1882, had shown that traces of albumin were sometimes met with in healthy urine. Later on it was shown that the albumin was a sero-albumin, and that it could only be discovered by delicate methods. In other more recent times, a real albuminuria had been observed in persons who showed no symptoms of disease, at any rate they had no kidney disease. This had been called functional or idiopathic albuminuria, and it was a question whether the symptom was a pathological or a physiological one. Leube had shown in 1878 that after heavy marches soldiers not infrequently had albumin in their urine. The idea, however, could not be rooted out that normal urine was free from albumin, and this arose from a misunderstanding or mixing up of the terms abnormal and pathological, and there were many abnormalities that were not pathological. There was a so-called physiological glycosuria, and a physiological

acetonuria, &c. It was, therefore, not strange that after violent exercises such as football, &c., or after a hearty meal, there should be some albumin in the urine. Rapp found albumin in cadets in 1.7 per cent. of the cases. Menstruation caused albuminuria in many women, and cold baths also, and albuminuria was pathological when it appeared under normal conditions, and not when it occurred under certain conditions and disappeared when the special condition ceased.

Another kind was the cyclic or orthotic, which occurred in children when they were moved from a horizontal to an upright position, but this was certainly pathological. In all these forms the albumin hardly ever exceeded  $\frac{1}{2}$  per cent. As regarded cold baths, the blood film was altered by cold baths; a leucocytosis developed in the blood stream, and these multinuclear leucocytes could exert an influence on the kidney. Rosenbach had made the interesting observation that in periodic hæmoglobinuria albumin was present in the urine even at the commencement of an attack; even in incomplete attacks from cold there was always albumin in the urine. Under such circumstances the albumin was pathological. Of the causes of albuminuria in menstruation he knew nothing.

After copious meals the circulatory condition played a part. Possibly the flow of blood from the kidney was hindered by distension of the abdomen, or there might be open communication between the portal vein and the general venous system. In the normal condition such communication might remain open, so that albumin might get into the circulation without going through the liver at all.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, December 10th, 1904.

HEPATIC RUPTURE.

At the Gesellschaft der Aertze, Schnitzler presented a drayman on whom he had operated for rupture of the liver. Nine hours after being crushed by a cask of beer, the patient was brought to hospital in a very anæmic condition, the abdomen greatly distended, both flanks dull on percussion, while the hepatic dulness was normal. A tear of the mesentery was diagnosed, and laparotomy decided upon as an immediate operation.

On opening the abdomen a large rent in the liver presented itself, the mesentery between the stomach and liver being torn. Two litres of blood were removed. The rupture was located in the lower and posterior margin of the left lobe, in which a man's fist might be placed. As stitches in this position were almost impossible, the hæmorrhage was checked by temporising with a weak solution of adrenalectin, conducted through the upper angle of the abdominal wound.

The case is interesting from the sequelæ, as embolism of the left lung speedily followed the recovery from the accident. At the present time infiltration and shrinkage of the lung still exist. The morbid changes are likely to have arisen from primary embolism of the hepatic cells, from which fragments were carried along the pulmonary artery to the lung, where the destruction took place. Schnitzler thought as far as the wound of the liver was concerned it would heal itself without much trouble, but the danger lay in the stypic.

Here he read a published case of hepatic rupture where no operation was performed, which nine months after the accident discharged in the form of a subphrenic abscess, large sequestra of liver being found in the purulent matter.

Lotheissen had another case to show the members where the tear in the liver was more superficial than either of the two cases previously described. The patient had been engaged in removing benzine when one of the casks exploded, throwing him violently to the ground on the abdomen, rupturing the liver. When

received into hospital he was anæmic, abdomen tense and painful, especially over the umbilical region. Both flanks were slightly dull, and no blood in the urine. Five hours after the accident he was operated upon, and about two litres of blood taken out of the abdomen. It was then discovered that the left lobe of the liver was torn, leaving a rent that would hide a good-sized apple. A portion was hanging by a pedicle, as thick as the finger. Four stitches were applied, over which was placed a pad of iodoform gauze, while the pedicle was removed by the Paquelin to prevent hæmorrhage, and finally a tampon of gauze placed between the stomach and liver, which was ultimately removed by the upper angle of the abdominal section. The bleeding in this case was checked by the Matratzen stitches, which were first so successfully applied by Hocheneegg. The prognosis of subcutaneous rupture of the liver is never very favourable according to literary statistics, but probably depends largely on the extent of the rupture and the time that elapses after the accident before operating.

#### INVAGINATION CAUSED BY ADENOMA.

Haim showed a case on which he had operated for invagination of the bowel, said to be due to the presence of an adenoma. The patient was a male, æt. 65, who had suffered for some time from colicky pains in the abdomen, but no vomiting or meteorism was present at any time. After one of these attacks he was brought to hospital with stoppage of the bowel, with meteorism and vomiting on this occasion. There was tenderness on pressure over the ileo-cæcal region, no convulsive contractions of the bowel to be observed, nor uncontrollable vomiting, and neither stool nor gas passing from the bowel, although the patient confessed that he was fairly well otherwise. After considering all the symptoms, the case was diagnosed as strangulation of the ileus, with probably a tumour in the ileo-cæcal region as the cause.

On operating it was found that a portion of the small intestine had become invaginated immediately above the tumour, which was resected along with 15 centimetres of the bowel. The wound was closed in the usual manner, and the patient speedily recovered. The microscopic examination of the tumour proved it to be a malignant adenoma, which, according to clinical history, is a rare morbid process of the bowel.

#### NEPHRITIC CALCULI.

Konigstein gave the history of a case of a female from whom he removed a large stone from the pelvis of the kidney, which had its origin from an attack of gonorrhœa. The stone was of a dark red colour, about the size of a hazel nut, and embedded in a quantity of pus, mucus, and chalky matter.

She had been seven months married, æt. 22, and had had urethritis, cystitis, endometritis, and swelling of the left adnexa, due to gonorrhœal infection from the husband. On examination over the left kidney, which was tender, fluctuating and swollen to the size of two good fists, the diagnosis was conclusive that operation was desirable. She was generally ill with high fever and nephritic colic, and a large quantity of pus in the urine prompted immediate interference. The pelvis of the kidney was greatly distended, the stone and debris evacuated, after which the temperature fell to normal, and the patient speedily recovered.

#### COLOUR IMPRESSIONS ON THE SENSES.

Urbantschitch again treated the audience to a discourse on the various impressions produced by different colours. This condition is variable in different individuals. It sometimes happens that this mental condition is produced by one eye affecting the hearing on the same side of the body. The acuity of hearing has much to do with the production of colour. He finds that many persons have their taste perverted by colour, so much so that sugar may taste bitter or salt, and bitter sweet. No particular colour can be said to raise or lower this sensation as a general rule, but many individuals are subject to their influence. Any one with a favourite colour may have the sense excited by simply applying the rays to the skin. All these

experiments must be conducted when the body is at perfect rest, or fallacies will obtrude themselves.

## Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, December 7th, 1904.

### THE VALUE OF KOPLIK'S SPOTS IN EARLY DIAGNOSIS OF MEASLES.

IN the last number of the *Orvosi Hetilaps*, Dr. Navratil says that he had looked for the spots on the buccal mucous membrane, first described by Koplik as preceding by some days the general eruption of measles, and had found them in 24 cases. In one case they preceded the eruption by 6 hours, in 11 cases by 24 hours, in 3 by 32 hours, in 4 by 48 hours, in 2 by 3 days, and in 2 by 6 days. The spots were generally situated on the mucous membrane of the cheeks opposite the molar teeth, but occasionally also on the lips, beginning as slightly raised, bluish-white, circular, sharply-defined points, in size less than a pin's head, and surrounded by a narrow red areola. In a few days they generally increase slightly and become more prominent, and the areola enlarges and becomes irregular in outline. Their number varied between six and twenty, and the time during which they persisted from two to six days. They were most marked just before or at the time of the general eruption. They were not present in fourteen cases. Since they are never seen in other conditions accompanied by fever, they become of the greatest importance for the early diagnosis of measles. Navratil claims that the buccal eruption in measles was first mentioned by Gerhardt, and that their importance was recognised by Filaton in 1895, a year before their independent discovery by Koplik.

#### RADICAL TREATMENT OF VARICOSE ULCERS.

Dr. Polyák writes that, though some varicose ulcers on the leg heal with almost any dressing such as iodoform, zinc ointment, aïrol or xeroform, the greater number resist such treatment, or if they heal quickly relapse. For such, skin-grafting, after thorough disinfection of the ulcer, is by far the best local treatment, but whenever extensive varicosities are present, this is also unsatisfactory. The only radical treatment in such cases is to ligature the saphenous vein according to Trendelenberg's method before proceeding to the transplantation of the skin.

#### Dr. Huber has contributed a valuable paper on the PREVENTION OF RECURRENCES IN SYPHILITIC DISEASES OF THE EYE.

He believes that he prevents recurrence in syphilitic ocular disease by the following treatment:—In syphilitic disease of the choroid, mercurial inunctions should be undertaken for two years, the place of inunction being varied daily. The dose should not exceed 30 gr., and according to the age and constitution of the patient, doses of 8 gr., or 15 gr. are better. After every ten inunctions a pause of four days may be made. The best base for the mercurial ointment is lanolin. Longer pauses than three weeks should not occur in the whole two years. A pause of three months completely nullifies the treatment.

Potassium iodide has no curative influence on ocular syphilis, but is directly injurious on account of the conjunctivitis to which it predisposes, and should not be given in the majority of cases. Potassium iodide has only one use in the treatment of ocular syphilis, namely, to counteract the injurious influences of large doses of mercury.

## The Operating Theatres.

### GUY'S HOSPITAL.

NOVEL AND VERY EFFECTIVE MODE OF TREATMENT OF GENERAL SUPPURATIVE PERITONITIS.—Mr. ARBUTHNOT LANE operated on a man, the subject of an acute suppurative peritonitis, clearly the result of appen-

dititis, of three days' duration. The muscles of the abdomen were very rigid, and the abdominal wall did not move during respiration. An incision was made along almost the entire length of the outer margin of the right rectus. The distal portion of the appendix, which was abruptly kinked about its centre, was gangrenous, and the foul-smelling pus which had formed about it was retained by fairly firm adhesions. The abdomen contained a large quantity of turbid fluid, which was not exactly offensive in smell, but was certainly not sweet. The peritoneum covering the intestines was inflamed throughout. The appendix was removed and its stump inverted by a purse-string suture. The wall of the abscess was thoroughly cleaned with pads wet with normal saline solution. The intestines were then turned out through the incision and every portion of the abdominal cavity and of the protruding viscera were thoroughly irrigated with a very large quantity of warm normal saline solution. Owing to the retraction of the muscle wall it was obvious that the apposition of the margins of the incision would entail a great loss of time, a very serious matter in the patient's critical condition, and when effected would exert a very great pressure upon the dilated and inflamed intestines, and prevent the passage of their contents. In such cases, Mr. Lane said, he used to cover in the intestines with cyanide gauze soaked in saline solution, and retain them with a towel used as a binder; but recently he had adopted a more efficient method. He had brought the margins of the skin together with a continuous horse-hair suture, leaving a gauze plug or drainage-tube, or both, in the situation of the appendical abscess. The distension has then been relieved with turpentine enemata, supplemented by calomel or other drugs if necessary. When the peritonitis subsides he reopens the wound and brings the cut edges of muscle together. As the muscle wall is lax, and the intestines are no longer distended, this is done easily. By this means, he pointed out, the operation is performed rapidly and with the greatest possible efficiency, while the obstruction resulting from the distension of the intestines compressed by the rigid abdominal wall is removed. The intestines occupy the considerable interval between the edges of the muscles and beneath the thin, loose skin. By this simple means he had been able to save many lives, which would not have been the case with the methods usually employed.

**EXCISION OF THE RECTUM AND LOWER PORTION OF THE SIGMOID FOR CANCER.**—The same surgeon operated on a woman, *æt.* 36, who had a carcinomatous ulcer in the lower third of the rectum, about three-quarters of an inch in depth. It did not involve the vaginal wall, but it appeared to be adherent to the anterior surface of the sacrum. Mr. Lane remarked that he had for a long time advocated a more effective method of dealing with cancer of the rectum than that usually adopted, namely, of attempting the removal of the growth and the affected glands from below, such removal being rendered possible in extensive cases by the cutting away of a variable portion of the sacrum. This operation he considered barbarous and useless. It leaves the patient in discomfort, and often in misery, for the reason that it is often necessary to pass bougies in order to keep the aperture open, and the process of dilatation is painful in the extreme; the patient looks forward with dread to its performance. Again, he

insisted that it is impossible in a very large proportion of cases to deal effectually with the glandular infection by this method of operating. He considered all such operations a reproach to the surgery of the present day. The method he employs, he said, is equally applicable to the male or female, and is accompanied with very little risk. The patient was placed in the semi-prone, or lithotomy, position; the anus was closed by a suture; the parts were cleansed, and the lower part of the aperture of the bowel was encircled by an incision through which it was freed as far as the peritoneal reflection. The patient was then put on the back, and a long incision was made in the left iliac region. The sigmoid was exposed and the adhesions which usually shorten up its mesentery and possibly attach the intestine itself were carefully divided. These result from the obstruction offered by the growth. Mr. Lane said he had already fully described them. The freeing of these adhesions, he pointed out, enables the surgeon to bring the sigmoid out through the edges of the wound. The primary growth was then examined and the extent of glandular infection accurately determined. This, Mr. Lane demonstrated, can be done with perfect accuracy and great facility, and he had often been surprised with the extent of the glandular infection. In this particular case, although the primary growth was small and low down, glands of considerable size were present in the meso-sigmoid, eight inches from the primary growth. The sigmoid was ligatured well above any large glands. It was cut through above the ligature and the lower ligatured end was inverted into the distal bowel by means of a purse-string suture, and a tube connected with a removable rubber bag was tied into the upper part of the sigmoid. The lower part of the sigmoid, with an area of meso-sigmoid extending well beyond any glandular infection, with the rectum and meso-rectum, were all freed from their attachments the greatest care being taken to remove any secondary focus of infection. The abdominal wound was closed except where the proximal portion of sigmoid escaped through it. The patient was then placed in the semi-prone or lithotomy position, and the bowel was removed from below. Most of the anal aperture was closed, a plug of gauze being left in for a few days to drain the pelvis. When removed, Mr. Lane said, the remaining aperture either closes spontaneously or with the help of a suture.

The advantages of this method are, in Mr. Lane's opinion, (1) the complete removal of any fear of infection; (2) its freedom from any discomfort whatever after the operation; (3) the fact that the greatest possible benefit is obtained at a risk which is probably less than that incurred in the usually utterly inefficient method.

#### City Hospital for Diseases of the Skin, Dublin.

THE annual meeting of this hospital was held on November 30th, the Lord Mayor of Dublin in the chair. The report, which was read by Dr. C. M. O'Brien, stated that during the year ending December 31st, 1904, the attendance of patients numbered 658. Fifty-nine patients had undergone the light treatment. Of forty-nine cases of lupus, twenty-nine had been cured by this treatment. Of ten cases of cancer treated by rays, three had been quite cured. Among those who proposed resolutions at the meeting were Rev. J. Burke, Rev. P. Hayden, and Dr. Tobin.

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 14, 1904.

**THE LONDON HOSPITAL "FUNDS" AND THE SMALL HOSPITALS.**

WE are glad to find that at length the Hospital Sunday and the King Edward VII. Hospital Funds have found a voice. As the trustees of large sums of money confided to their care by the public they are clearly open to criticism and should be prepared at all times to justify their action in particular instances. For our own part, we have always credited those bodies with the highest possible standards of aim and purpose, but, at the same time, we have never hesitated to point out what appeared to us to be defects in policy or in administration. Our views have been expressed with moderation, and we beg to refer all who are interested in this discussion to the tone of our remarks in a leading article of November 30th. It would be impossible for anyone having read that article to imagine that our position was prompted by any desire other than to secure by means of friendly criticism and suggestion a possibly more perfect justice in the administration of the grants issued by the Funds, and that our opinion of the inherent soundness and absolute good faith of those important public bodies was of the highest. Our aim, we repeat, is to secure an administration of the Funds that shall be free from the slightest suspicion of unfairness. The *Hospital*, an excellent journal, if not exactly a purely medical contemporary, has assailed us in the severest terms for a chance expression in a recent issue. The passage in question spoke of the host of small but deserving medical charities that had been injured in reputation and in income by not receiving grants from the Sunday and the King Edward Hospital Funds. The word "host" is obviously an over-statement that has escaped the editorial vigilance. The use of the word "host" would hardly be warrantable if applied to the

whole of the London hospitals taken together. Indeed, so clearly has the word been used in error that we wonder that any experienced editor could possibly take exception to a slip which he is bound to fall into sooner or later in his own columns, possibly and probably in a far more serious form. Indeed, forbearance towards obvious editorial lapses is a sort of unwritten but cardinal law of the better kind of journalism. However, we have no intention of declining responsibility for the statement in question. The Editor of the *Hospital* calls upon us in the name of responsible journalism to justify a certain phrase. In the name of responsible journalism and in support of the honourable traditions that have always governed THE MEDICAL PRESS AND CIRCULAR we withdraw that phrase and regret that it should have inadvertently crept into our columns. Sir Henry Burdett, however, must pardon us if we point out that, having disposed of this minor preliminary, we shall expect him to answer the rest of our criticisms. If he can furnish a full and satisfactory answer we shall be pleased to reconsider our criticisms and to give that fact the widest possible publicity. He must not think, however, that by pointing out a mere inadvertence he is relieved from answering the rest of the issues we have raised. That method of avoiding full discussion is not uncommon with controversialists of a certain type who imagine that to detect a flaw in an opponent's statements is to answer his whole question. Sir Henry Burdett has now come forward on behalf of the King Edward Hospital Fund. He may be reminded that similar criticisms to those under consideration have appeared in this journal for years past but have hitherto remained unanswered. Why, then, should he complain bitterly because of a delay of a week or two in answering his triumphant exposure of a clerical error? On the one hand, the principles of distribution adopted by a great public trust have been criticised year after year by an old-standing medical journal, but the editorial energy of Sir Henry Burdett lay dormant until a word was used which chanced to express in hyperbole more than was warranted by facts. If the public and the medical world can wait five or six years for an explanation of such serious matters from Sir Henry Burdett, surely he can wait a week or two for the explanation of a verbal slip in a journalistic article. It is to be hoped that now the subject has been fairly launched before the public it will not be allowed to drop before the constitution and the policy of the Hospital Funds are clearly stated and discussed. This result we anticipate with some amount of confidence, as it was only after our direct appeal to His Majesty the King that the matters to which we drew attention have been brought into the arena of public discussion. We doubt not that the well-known fairness of mind and love of absolute justice of His Majesty will ultimately secure full recognition of all medical charities, great and small, by his own Fund. Other matters raised in regard to the Funds will be dealt with in successive issues.

## CENTRAL BRITISH RED CROSS COUNCIL.

AN appeal is being made by Lord Knutsford, as chairman of the Central British Red Cross Council, for personal and financial support to be given to the excellent cause of which he is the official head. This cause, it will be recollected, is the preparation and organisation, in time of peace, of voluntary agencies for supplying help and reinforcement to the medical services of the Army and Navy in time of war. It may be argued that the energies of those interested in the welfare of the sick and wounded in war might be more usefully employed in securing an efficient medical department to the two arms of our national defence than in merely trying to supplement what is defective in their preparations. And so indeed it would be, if every campaign that has taken place had not shown the same waste of life and intensification of suffering, due to the same causes, reproduced with unerring regularity. We need hardly point out what those causes are—official neglect, official short-sightedness, and official incompetency. The price is always the same—in flesh and blood—and the price is always paid. Reform schemes are drawn up and improvements are set on foot with a flourish of trumpets; only to dwindle away and die of inanition as soon as the popular fervour is directed to some other object. It is of the essence of any scheme for properly serving the Army and Navy with doctors, nurses, hospitals, and stores that it should be possessed of an almost inexhaustible amount of elasticity, so that as wastage occurs and more troops are needed the department should be in a position to supply the medical reinforcements automatically. A fixed department with cut and dried resources soon reaches the limits of its capabilities, and then come haste, bustle, and blundering, with their accompaniments of extravagance and inefficiency. The lesson has been taught over and over again, and as many times neglected, so that the only man who could oppose the necessity for such work as the Central British Red Cross Council are engaged upon would be one who is thoroughly satisfied with the preparedness and aptitude of the medical arms of the Services. Such a man, if he exist, must be an incurable optimist, and may well be excluded from the scope of Lord Knutsford's appeal. But to those who admire our soldiers and sailors and are concerned for their welfare—to those, that is, who constitute the bulk of the nation—the work of the Red Cross Council must be a matter of deep concern, and one worthy of substantial assistance. The Council was formed in 1899 with the object of co-ordinating and bringing into line the admirable Associations which have sprung up sporadically to meet one or another deficiency in the humanitarian armament of the country, but which, if left to themselves, must unconsciously overlap and duplicate each other's work. Fortunately these associations have succeeded in obtaining recognition from the heads of the Army and Navy through the medium of the Central British Red Cross Council, and they may now be regarded as integral portions of the country's

defence. Everyone, therefore, should feel called upon to contribute to the maintenance of their resources in finance and *personnel*. But though the Red Cross Council is the channel of communication between the War Office and Admiralty on the one hand and the voluntary associations of the other, its position remains that of a mere channel, and it has in itself no other duty than that of helping unofficial bodies to do their work to the best advantage. For this reason there is no little danger that it may fail to excite the interest and support that it deserves, and we hope that Lord Knutsford's appeal may have the effect of drawing subscriptions to its funds and of bringing forward the leading people of counties and large towns to aid in forming committees to promote its objects. The haste with which the various voluntary hospitals were organised during the South African War and the regrettable waste of money that that haste entailed in many cases are still fresh in the public mind, nor should the want of harmony and direction that prevailed as the result of these spasmodic and irresponsible efforts be forgotten. No great naval war in which this country has been an active participator has occurred within living memory, but can it be reasonably doubted that similar confusion and ill-directed energy would characterise efforts to aid in mitigating the horrors of a long-drawn out sea-fight with a first-class power? The appeal comes at an appropriate moment when people are just recovering from the shock of the Dogger Bank incident and the startling suddenness with which it brought home to everyone that there is sometimes but one step between us and a European conflagration. A war with such a country as Russia would soon have exhausted the resources of even the reorganised Army Medical Service, and the voluntary agencies would have come forward to supply the want with their old vigour and, we fear, with their old want of co-ordination. *Si vis pacem para bellum* is as true of the humanitarian as it is of the bellicose preparations for war, and the way to aid the sick and wounded when the hour comes to succour them is by carefully organising in peace time the efforts of those who would help to that end. The Red Cross Council aims at establishing committees in each county, which will be left free to decide in what way they will render assistance—whether by preparing auxiliary hospitals, hospital ships, convalescent homes, or hospital trains. By this plan full play will be given to local aptitude and predilection. We hope that the response to the appeal will be commensurate with the natural importance of the issues involved.

## SOME ASPECTS OF OVERCROWDING.

THE general report of the Census Commissioners provides many interesting problems for the sanitarian, but we have still to deal with the moot question of overcrowding. The Census confirms the growing inclination of the population to leave the country districts and to flock to town. We find that persons occupied in agricultural pursuits



declined in numbers by 6·2 per cent. since 1891. Even this does not convey the most serious aspect of the phenomenon, for we find the decrease in the number of agricultural labourers actually 18·9 per cent. On the other hand there was an increase of 20·4 per cent. of persons employed as gardeners and in market gardening. This would show that it is high time we should recognise the new conditions under which agriculture must be pursued in Great Britain. The serious falling off in agricultural labourers mitigated by the increase of other classes employed on the land would seem to point unmistakably to the necessity for intense cultivation. This practically amounts to the need for a revolution in our system of land tenure. We require smaller holdings and a multiplication of allotments. It is clear that there is a movement towards decentralisation, but this does not really mean that the people are going back to the land; the real fact is, that large towns are spreading outwards, the suburban population is increasing by leaps and bounds, and we have here one explanation of the rise in cost of local government. It appears that the general increase in town population was 40 per cent. between 1891 and 1901, as against 12·2 per cent. between 1881 and 1891. The average increase for all London between the two last Censuses was 7·3 per cent. There was, however, a decrease in the dwellers of Central London, and also in Westminster and Chelsea. On the other hand we are confronted with the astounding increase of 193·5 per cent. in East Ham, 105·3 in Walthamstow, 87·4 in Willesden, 61·4 in Hornsey, 56·7 in Leyton, 43·7 in Tottenham, 13·5 in West Ham, and 30·4 in Croydon. This state of affairs is not confined to the Metropolis: the same conditions are found to exist in the large industrial centres of the provinces. Birmingham itself shows an increase of 9·2 per cent. only, but the accumulation of the population in the immediate neighbourhood has been far more rapid, and in Kingsfield and Northfield we find an increase of 101·5, at Handsworth 61·6, and at Smethwick 51·1. At Liverpool the increase was 8·8 per cent., but at Wallasey, on the opposite side of the Mersey, the increase was 61·2, and there is an equally marked increase in other suburbs of the great seaport. In spite of this agglomeration of the population, there is a distinct decrease in actual overcrowding, that is to say if we take overcrowding to mean that more than two people inhabit one room. This decrease is to be observed in all parts of the country, both urban and rural. We will deal with this in greater detail. At the last Census there were 6,260,852 houses inhabited, which shows an increase of 14·87 per cent. since 1891. The houses "in a state of building" showed an increase of 60 per cent., which is heavier than any previous record. The average number of persons per house in towns was 5·4 and in rural districts 4·6. The lowest urban average was 4·34 at Great Yarmouth, and the highest was 8·85 at Devonport. The average for London was 7·93, which compares with 7·73 in 1891. But the density varied considerably

in different districts. For instance, in Stepney 33 per cent. of the entire population was living in an overcrowded state; even this was not the worst, for in one of the parishes, St. George's-in-the-East, the overcrowded percentage was 45. The total number of persons living in an overcrowded condition was 481,653 in 1891, dropping to 392,414 in 1901, showing respectively an average of 11·2 and 8·2 per cent. of the total population. This is a result which, though satisfactory, should spur on local authorities to do still better in the future. We have heard a great deal about the alien invasion, though this is bad in the results it impels on certain restricted districts, the general outcry has been somewhat exaggerated. It is true that foreign population in our midst has trebled since 1861. At the last Census there were 106,000 more than in 1891. More than half of the total were to be found in London, and 20,000 in the adjoining counties. The remainder of the foreigners were almost entirely to be found in the large seaport industrial centres. While in London generally there were 30 foreigners for every 1,000 inhabitants, in Stepney there were 182 foreigners for every 1,000 inhabitants, which compared with 113 in 1891, and 57 in 1881. In Holborn, the proportion was 92 foreigners to 1,000 of the population. There is, therefore, some justification for the statement that the presence of the poorer foreigners connotes overcrowding, and although the evil may not be very general or very great, yet we know what deteriorating effects on the whole population danger-spots have. It is clear that much still remains to be done not only in inducing the people to go back to the land, but also in improving the poorer quarters of our great cities. That we have reduced considerably the number of single room tenements, and, in fact, all tenements with rooms below the number of five, should be an incentive to greater efforts in the future.

### Notes on Current Topics.

#### The Metropolitan Hospital Sunday Fund and the Small Hospitals.

WE have received a letter from the Honorary Solicitor of the Metropolitan Hospital Sunday Fund calling in question several statements that have appeared in THE MEDICAL PRESS AND CIRCULAR. This action of the Fund we welcome as a preliminary step to full discussion of the administrative policy of an important public body. We hope to enter fully into the points raised in an early issue. Similar criticisms have been published for years past, but as the Hospital Sunday Fund has hitherto allowed them to be taken by default as granted in the absence of any question or contrary assertion, there can be no overpowering need for hurry in our reply. We note a tendency, moreover, on the part of our correspondents to confuse issues. Meanwhile, we can assure the Hospital Sunday Fund of our complete sympathy and respect, which is in no way alienated by what we conceive, perhaps mistakenly, to be

our duty in inviting public attention to certain points in the policy of the Fund that appear more or less open to improvement. If the Fund can justify their system of grants and of withholding grants we shall be the first to withdraw our criticisms and to accord our hearty approval.

#### Suburban Sanitation.

IN no surroundings is there need for more careful sanitary supervision than in the suburbs of our large towns. They usually appear as typical abodes of health, with their roomy houses, green lawns, and clear skies. But just on account of this appearance of rude health, so to speak, is there the greater risk of overlooking the want of proper sanitation and hygienic precautions. It is not uncommon to find, especially in rapidly-growing districts, that a water supply or a drainage system is being strained beyond what it can bear. The sewer that was large enough for a population of five thousand is inadequate for one of seven. It is unusual to find in suburban districts any rigorous attention given to the supervision of the food supply. Milk which could not run the gauntlet of the sanitary inspectors in a town may often be purveyed without question outside the town limits. There is, again, but little care taken as to the site of new buildings. Many are put up with haste on ill-drained fields, or even on rubbish-heaps, used for filling quarries or sandpits. Scattered here and there between the houses of the well-to-do are little congested areas of dwellings for the poor. In them the conditions are often worse than in the crowded tenements of the city, for supervision by the health authorities is more often absent. There may be no water supply, and for sanitary convenience only a privy which is rarely cleaned. A well or pump in close proximity supplies the drinking water, and near at hand is an ash-heap containing garbage of all sorts. This statement of conditions is true of many a suburban district, though, of course, on the other hand, many are veritable health-resorts.

#### Human and Bovine Tuberculosis.

THE last word in the controversy as to whether human and bovine tuberculosis are the work of the same or different organisms remains yet to be pronounced. Professor Koch still sticks to his guns, but none of his arguments or their own experiments have yet convinced the Royal Commission on Tuberculosis that there is any recognisable difference between the organisms. Indeed, their conviction as to the identity of the bacilli is fairly well established. It is interesting, therefore, to note that the recent report of the Imperial Commission on Consumption appointed by the German Government some time ago asserts strongly that the bacilli are absolutely distinct from one another biologically, and that one bacillus can never be made to develop or change into the other. On the other hand, though they find tuberculosis in man to be generally due to the bacillus of human tuberculosis, it may in some cases be caused by the bovine bacillus. In fifty-six cases of persons

dead of tuberculosis, they found the human bacillus in fifty and the bovine in six. Three of the latter were young children, whom it is reasonable to assume may have contracted the disease from infected milk, and the practical lesson that stringent precautions should be taken to eliminate tuberculous cows from dairy herds receives additional confirmation by this finding. After Koch's startling pronouncement at the International Tuberculosis Congress in London, there was considerable danger that those who defied the regulations would quote his authority to support their attitude; fortunately, now they will not have that excuse.

#### Pneumonia in Chicago.

WE drew attention not long ago to the extraordinary death-rates due to pneumonia in some of the American cities, and to the attempt which is being made by a committee of experts to discover some method of meeting this veritable scourge. In Chicago the deaths from pneumonia make up no less than 16 per cent. of the total, and have shown during the past few years an alarming tendency to increase in number. In fact, in 1900, the percentage was 13½, and each year since shows a regular increase. It is but little satisfaction that at the same time as this change has been going on there has been a slight diminution in the number of deaths from phthisis, for it is not nearly enough to make up for the increase of the other disease. It is, indeed, a discouraging thing to sanitary practice that at the moment when we seem to be gaining some control over most of the infectious diseases, pneumonia denies all restraint. Last year in Chicago it caused 50 per cent. more deaths than all the other infectious diseases combined, including cerebro-spinal meningitis, erysipelas, diphtheria, influenza, malaria, measles, mumps, scarlatina, small-pox, typhoid fever, whooping-cough, and puerperal fever.

#### The Action of Sugar on the Uterus.

SOME of the simplest remedies lie ready to one's hand; so close, in fact, that they are persistently overlooked. Many have been the drugs used and various have been the devices employed by the harassed accoucheur to expedite labour, and yet had he known it a lump or two of sugar would have done all he wanted. At least, so one would gather from the researches of Keim, (a) who had been acquainted with the fact for six years, but hesitated to make it fully known till stimulated by Marquis, another worker in the same field. Lactose he believes to be the most efficacious sugar to administer, and this is readily absorbed in late pregnancy owing to the usual hepatic insufficiency. In labour, if the os is a long time in dilating, the glycogen in the blood is used up and the uterine muscle needs more carbohydrate to help it in its work. If this deficiency be supplied by the administration of sugar, the muscle gains fresh vigour and begins to contract with renewed

(a) *Archiv. gen. de Med.*, September 27th, 1904.

energy. The best time to give sugar is two and a half hours after dilatation has begun in multiparæ and three and a half hours in primiparæ. When, however, the os has dilated considerably, giving more sugar hurries on the process of labour markedly, especially if inertia is threatening. A case is quoted of a multipara, whose labours usually lasted one or two days, being given sugar fifteen hours after her pains began. Within one hour the child was born. Stress is laid by Keim on the fact that, unlike drugs such as ergot and quinine, sugar is not toxic, is always available, and acts not only on the muscles of the uterus but also on those of the abdominal wall. The prescription has the added advantage of being a palatable one. Doubtless the accoucheur of the future will improve on crude lactose as the vehicle of administration of carbohydrate, as it may happen that shortly a box of Fuller's sweets will be deemed as essential an item in the equipment of the midwifery bag as forceps, chloroform, and perchloride tabloids. We trust that the present rise in the price of sugar may not interfere with the proper trial of the remedy.

#### The Surgical Examination at Edinburgh.

It is with considerable interest that the profession will await the further inspection of the final surgical examination of Edinburgh University as ordered by the General Medical Council. With this pending it would be unfair to make any comments on the questions at issue, as there are serious differences of opinion, if not of fact, between the visitor and inspector on the one hand, and the medical faculty of the University on the other. We are not precluded, however, from criticising the method and manner of the report of the visitor and inspector. These gentlemen, who, no doubt, have performed a difficult duty with perfect honesty and *bona fides*, seem to have given an unusually wide meaning to the terms of their commission. They took no steps to discover the lines laid down for their guidance in the Standing Orders of the Council, and, in consequence, they erred both by omission and commission. On the one hand, they have not kept, at any rate as official documents, diaries of their inspection, and have therefore been unable to point to specific instances of the general faults of which they speak. On the other, they include in their report a quantity of extraneous matter in the way of general discussion of the ideals of medical education and examination. Under the circumstances, the General Medical Council has had practically no alternative but to order a re-inspection of the surgical examination at Edinburgh. We may add that it is fortunate for Sir George Philipson and Mr. Bryant that they had not to submit their report for the criticism of the Regius Professor at Cambridge or any other medical stylist. Many of their sentences are so long and complicated as to recall vividly the famous letters a certain peer addressed to the *Times* a few years back on ecclesiastical subjects.

#### Red Cross Work in Japan.

MISS McCAUL, in her recently published book on her experiences in Japan and Manchuria, gives an account of the organisation of the Japanese medical department which should make the mouths of our reformers water. Miss McCaul was sent to Japan to inspect their Red Cross work in actual operation, and thanks to the courtesy she received she was able to make a pretty complete study of it. The chief reason of her success lay apparently in her assuring the authorities that she "had come to learn and not to teach," and as our little allies take a considerable pride in their work, and resent being patronised, this declaration acted as the "open sesame" of the hospital doors. What struck Miss McCaul particularly was that the Red Cross Society is a great national organisation permeating every class in the country; none are too noble and none too poor to be influenced by it. One plain "nurse" that Miss McCaul met afterwards proved to be the Marchioness Nabéshimá—a lady of high rank and distinction. But although nursing sick soldiers is regarded as a pleasure and a duty by ladies, Manchuria does not seem to suffer from Sir Frederick Treves' "plague of women." for all the women know how to do their work and make it their business to carry it out without regarding their toilettes and prospects of getting husbands. Great care is bestowed on the preparation and transport of food, whilst all along the route arrangements are made for the soldiers to fill their water-bottles with sterilised water. When one compares their enlightened, scientific, and orderly procedures in all these essential points with the scurry and muddle of the South African War, one is forced to admit that new civilisations have advantages which are denied to older ones. It would be rather humiliating to ask Generals Oyama or Kuroki to take charge of our War Office for five years; but we are inclined to think that worse suggestions might be, and have been, made in connection with Army reform.

#### The Public Health Laboratory at Boston.

No right-minded person thinks of questioning the dogma that "Boston is the hub of the universe." It is a necessary consequence that its new bacteriological laboratory "licks creation." Seriously, the organisation of public health work in Boston is as admirable a system as has yet been devised, and the description of the laboratory, as given in one of our American contemporaries,<sup>(a)</sup> is enough to rouse the envy of our sanitary officials at home. The laboratory supplies medical men with outfits to procure specimens of suspected sputum, membranes, blood, and so on, and these are distributed from, and collected at, various stations throughout the city. An ingenious device is made use of to obviate delay in the examination of diphtheria specimens which arrive after closing time. The laboratory closes at six,

(a) *Boston Med. and Surg. Journ.*, November 10th, 1904.

but, side by side with a big box for receiving other specimens is a chute for diphtheria specimens which leads directly into a small incubator. By this means an examination can be made, and a report given as soon as the laboratory opens in the morning.

#### The Study of Greek.

THE question of demanding Greek as a compulsory subject from students entering the ancient Universities has come up again in practical form. Oxford has already voted on the matter, and Greek is to remain obligatory on the banks of the Isis. Cambridge, however, has not yet registered its opinion; but a long and interesting debate has taken place on the report of the Studies and Examinations Syndicate containing the proposal. To medical men the question is interesting principally as affecting candidates for scientific and medical degrees, and there will be few, we think, who would be in favour of requiring a man who has shown a marked aptitude for the natural sciences to be forced to present a smattering of Greek as a preliminary to the serious study of his life. The difficulty of the Greek language is admittedly great, and the amount of ground that has to be broken in the way of grammar and accidence before any possible acquaintance can be made with the authors in the language demands years of close and attentive study. It is beyond dispute that the disciplinary value of such study can be obtained in many other ways, all of which would place the student in a position of more practical advantage than that of being able to hammer out a mediocre translation of Thucydides or Homer with the aid of a dictionary and a grammar. It is a compliment to Greek and Greek scholars to admit that proficiency in the language is reserved for the few, and we are glad to see that the Master of Trinity and the Provost of King's recognise the superior advantages of other studies for men whose minds are cast in a different mould from their own. It is much to be hoped that if the whole of the Syndicate's recommendations are not carried, the plan advocated by the President of Queen's may be adopted, and that while Greek remains compulsory for men seeking an Arts degree, an alternative degree, namely, a B.Sc., may be created for science students who would not have to pass in Greek as a compulsory preliminary to working for it.

#### Bacteria in the Stomach.

No clinical investigation of a case of gastric disease is now complete unless a chemical examination of the contents of the stomach be made. The value of this is rightly insisted upon by those who endeavour to place the affections of this organ upon a scientific basis. Microscopical examination of the material thus provided is of equal importance, for the recognition of undoubted cancer cells may be the only way of confirming a hitherto doubtful diagnosis of malignant disease. Now it seems as if a bacteriological investigation is also necessary if the physician is to have a right comprehension of the

case under his charge. The appearance of sarcinae and torulæ has been held to be valuable evidence of the existence of fermentative conditions within the stomach, whether in certain varieties of dyspepsia or in simple dilatation of the organ. Dr. E. Palier, of New York, working in Berlin, has examined thirteen samples of gastric juice from different classes of stomach disease. The results of the bacteriological tests which he has conducted with a view to further elucidating the pathology of dyspepsia and carcinoma are most instructive. Thus, in all cases of malignant disease staphylococci were found in great abundance. The so-called lactic acid bacillus, the same organism as is concerned in the souring of milk, is found to possess a flagellated extremity, and, because it is not a straight rod but bent in the middle, the author would apply to it the name of *Vibrio geniculatus ventriculi*. This germ will develop well in any medium which is deficient in hydrochloric acid, so that it is found plentifully in carcinoma. In cases of hyperchlorhydria, on the contrary, this organism is absent, but different varieties of yeast fungi and sarcinae flourish instead. These latter are, of course, absent in cancer. A knowledge, therefore, of the flora of the stomach will probably be of some assistance to the physician as well as to the surgeon.

#### Alcohol and Tremor.

A FINE muscular tremor of a static character is generally considered to be one of the signs of chronic alcoholism. When nervous control is impaired to such a degree that the condition becomes practically chronic, the tremor can be relieved up to a certain point by greater indulgence in the drug. The popular idea that alcohol "steadies the nerves," which is still only too prevalent, has probably arisen from a knowledge of its action in this respect. The tremor produced in this manner is toxic in nature, acting through the nervous system, though when once well established it is difficult to distinguish from other varieties of nervous tremor. It would appear that alcohol may occasionally be of some therapeutic value in controlling tremors of a totally different origin. The case recorded by M. Mayet (a) is worthy of note in this respect. The patient was a man, æt. 52, who presented the symptoms of disseminated sclerosis, from which he had suffered for many years. The volitional tremors were very severe, so that eating and drinking were difficult. The man had found, however, that these movements were almost entirely controlled by drinking a large quantity of wine; at any rate, he was by its means enabled to earn his living as a labourer. He had other signs of alcoholism, such as impaired digestion, disturbed dreams, and occasional excitement. An attempt was made as soon as he came under medical observation to substitute some other drug for alcohol in order to lessen the amplitude and intensity of the intentional tremors associated with his nervous disease, but each one was a failure.

(a) *Lyon Médicale*, November 27th, 1904.

Alcohol was the only thing that appeared to control them to anything like a reasonable extent. The *raison d'être* of its action in this case is not obvious, and it can hardly be supposed that the beneficial results will be permanent.

#### Alterations in Examination of the Royal University, Ireland.

THE Senate of the Royal University of Ireland has decided upon an important alteration in the examination for medical degrees held by the University. Up to the present the system of examination has been that first a general examination for all candidates is held, and that all candidates who obtain over a certain percentage of marks are allowed to present themselves for a further honours examination. The actual awards of honours and exhibitions are then made on the results of this honorary examination. This system has met with adverse criticism from both examiners and students for a considerable time, and various efforts have been made to have it altered. In future two separate examinations will be held simultaneously, one for pass candidates only, the other for honours candidates only. When entering for the examination, each candidate must state at which of these examinations he elects to present himself. A candidate who has entered for the honours examination may be allowed to change to the pass examination on giving a satisfactory reason for doing so, at least one week before the date of examination, but under no circumstance will a candidate who has entered for the pass examination be allowed to change to the honours examination. Honours and exhibitions will be awarded on the results of the honours examinations alone. It is impossible to offer a definite opinion on the merits of this system until it has been tested, but we are of opinion that it is preferable to the previous examination. We are, however, further of opinion a rule ought to have been added to the effect that candidates who had failed on a previous occasion to satisfy their examiners at either the pass or the honours examination should not be allowed to subsequently present themselves for the honours examination. Honours and exhibitions should be reserved for the most deserving candidates, and the most deserving candidate is not the man who has been rejected at a previous examination.

#### PERSONAL.

It is stated that his Majesty the King on his visit to Manchester next spring will take part in the inaugural ceremonies of the Sanatorium for Consumption in Delamere Forest, an institution which owes its existence to the generosity of the late Mr. W. J. Crossley.

MR. GEORGE C. FRANKLIN, Surgeon to the Leicester Royal Infirmary, will deliver his Presidential Address to the British Medical Association meeting at Leicester on Friday, July 25th, 1905.

THE address in Medicine at the Leicester Meeting will be delivered by Dr. Henry Maudsley, and the address in Surgery by Mr. C. J. Bond, of Leicester.

THE Earl of Derby, K.G., presided at the first dinner of the Manchester Medical School after its amalgamation with the newly founded University of Manchester.

PROFESSOR ARTHUR ROBINSON, of King's College, London, has been appointed to the Chair of Anatomy at the University of Birmingham, in succession to Professor B. C. A. Windle, now President of Queen's College, Cork.

THE Wilhelm Order, which is awarded in recognition of services rendered in the cause of the public welfare, has been conferred on Professor Robert Koch.

It is reported that Dr. William H. Welch, Professor of Pathology at Johns Hopkins University, Baltimore, will succeed Professor Osler in the Chair of Medicine.

DR. J. M. ENGLISH, New Westminster, British Columbia, has been appointed Resident Physician at Quesnel, in place of Dr. A. D. Morgan, who has resigned.

DR. HINDLE, who has ceased practice, and is leaving Askern, in Yorkshire, was on Thursday last, with his wife, the recipient of several handsome presentation gifts from friends and patients.

MR. JOHN TWEEDY, the President of the Royal College of Surgeons, on the 6th instant unveiled a window which has been erected in memory of Mr. William Cadge, Fellow of the Royal College of Surgeons, in Norwich Cathedral.

THE United Hospitals Clinical School of Liverpool held its first annual dinner at the Adelphi Hotel on December 3rd, Dr. William Carter, J.P., Senior Physician to the Royal Southern Hospital, being in the chair.

At a recent meeting of the Liverpool Medical Institution, Mr. E. R. Bickersteth, F.R.C.S., formerly president of the institute, and this year president of the Royal Infirmary, was cordially congratulated on the completion of his fiftieth year of membership of the institution.

MR. PRIESTLEY SMITH has resigned the appointment of Honorary Ophthalmic Surgeon to the Queen's Hospital, Birmingham, to the great regret of everybody connected with the institution.

PROFESSOR DEBOVE has been unanimously re-elected Dean of the Medical Faculty of the University of Paris.

PROFESSOR ARNOLD HELLER, Director of the Institute of Morbid Anatomy at Kiel, has been elected Rector Magnificus of that University.

As previously announced in this journal the Nobel Prize award for Chemistry has this year been made to Sir William Ramsay, Professor of Chemistry at University College. The sum of money attached to each prize is about £7,825.

KING OSCAR of Sweden made the Nobel Award in Physics to Lord Rayleigh, Professor of Philosophy at the Royal Institute.

ON the same occasion at Stockholm the prize in Medicine and Physiology was bestowed upon M. Pavloff, Professor at the Military Academy of Medicine in St. Petersburg.

PROFESSOR WINDLE, M.D., F.R.S., of the University of Birmingham, who was recently appointed President of Queen's College, Cork, was honoured on Thursday last with a public dinner under the auspices of the University at the Grand Hotel, Birmingham. Sir

Oliver Lodge, Principal of the University, presided over an enthusiastic gathering of Dr. Windle's late colleagues and friends, anxious to show their appreciation of his work in the past.

DR. GRAMSHAW, of York, has been presented by the Sheriff Hutton Free Gift Society with a handsome testimonial bearing the inscription—"Presented to F. Sidney Gramshaw, M.D., F.R.C.S. Edin., as a token of respect and esteem for nearly thirty years of faithful service.

### Special Correspondence.

(FROM OUR SPECIAL CORRESPONDENT.)

#### SCOTLAND.

LEUKÆMIA AND ALLIED DISEASES.—On Thursday last Professor Muir, of the University of Glasgow, delivered an instructive address before the Glasgow Medico-Chirurgical Society on this subject. By means of the lantern he showed numerous slides of the various forms of cells and the changes they undergo in the medullary form of leucocythæmia or what has often been called spleno-medullary leukæmia, as well as in the lymphoid form of the disease. In the course of his address Professor Muir stated that while in the chronic forms of the disease the rule was to find the spleen much, and oftentimes enormously enlarged, in other cases where the disease ran its course rapidly there might be very slight enlargement of the spleen. Further the enlargement of that organ was due to the multiplication of the cells or corpuscles and not to any marked fibroid change in the enlarged spleen. Coming to the diseases allied to leukæmia he referred to Hodgkin's disease, and to the confusion which has long existed with regard to the numerous terms applied to the general enlargement of the lymphatic glands throughout the body, such as lymphadenoma, lymphæma, lympho-sarcoma, etc. In this form of disease the cell proliferation was not so pronounced as in leukæmia, and there was certainly a distinct tendency to connective tissue growth—to a fibroid condition—existing in a marked degree. It was his opinion that there was an infective process at work in Hodgkin's disease, and that it was not of a tuberculous character. He made reference to the Transactions of the Pathological Society of London in 1878, on this subject, and to the writings of several American authors with whose views he was disposed to agree. Drs. Workman, Lindsay Steven, and Hunter took part in the discussion which followed, and generally expressed themselves as in complete agreement with the conclusions arrived at by Professor Muir, that while no organism had yet been found as the cause of the disease, that it was at least not a tuberculous process. On the motion of the chairman, Dr. R. M. Buchanan, a hearty vote of thanks was accorded Professor Muir for his instructive address which was listened to by an unusually large number of members of the Society.

THE GLASGOW MEDICAL CLUB.—For some years there existed in the city on the south side of the River Clyde, what was called the Southern Medical Club, the membership of which was composed largely but not exclusively of medical men belonging to the southern district of the city. A short time ago it removed its habitation to much more commodious premises situated at 22, Carlton Place. The name of the club has been changed to "The Medical Club," with the intention of embracing within its membership as many members of the profession throughout the city and the suburban districts as can be prevailed upon to join. The subscription is £1 1s. per annum, without any entrance money. There is a large room, forming the library, which is admirably adapted for holding medical society meetings. It is there the Southern Medical Society holds its meetings every alternate Thursday evening. It is also equipped with a billiard room, as well as a card room, and ample accommodation for caretaker. Since removing to the new premises a considerable

accession to the membership has been made, the new members being drawn from the different districts of the city. It is hoped that many others may see their way to join, and when the existing lease expires, as it does in four years, still larger and more central premises in the centre of the city may be procured. There is no reason why Glasgow, with over six hundred medical men practising in the city and suburbs, should not have a large and flourishing club where, perhaps, the various medical societies could hold their meetings, and where country members might find comfortable accommodation if required when visiting the city, with the advantage of friendly intercourse with their fellow practitioners. The club is managed by general, house, library, and amusement committees. It is proposed to set apart one evening of the week as a "house" night, and to have occasional social evenings. One such, held recently, was a great success, the musical talent being quite up to the average if not beyond it of such gatherings. With a further increase in the membership of the club its sphere of usefulness would be largely extended, and the interests of the profession might, perhaps, be more strictly conserved than at present obtains. This would at least be one way, and a pleasant one, of arriving at the accomplishment of such a very desirable end.

### Correspondence.

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

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

SIR,—This question is well worth full discussion. It would be interesting if "A Small Hospital Physician" would clearly explain what he means when he writes that "under the conditions that rule the hospital medical world of London, the only chance for any man not born into the purple lies in obtaining an appointment at a small special hospital." Special departments exist at all general hospitals; and if the unnecessary special hospitals were closed these departments would be enlarged, and their staffs increased to meet the demand upon them. Does your correspondent mean to imply that appointments to the staff of general hospitals are made with regard to anything save the professional attainments and personal qualities of the candidates. The appointments are controlled by professional opinion, and governed by the merit displayed throughout a career under the eyes of future colleagues when the candidate is an old student of the hospital, or well-known by careful inquiry when an outsider. The personal character, the professional ideals, the scientific and practical work and attainments of applicants for special appointments at general hospitals are thoroughly understood by those having the gift of the posts; and the danger of the offices being filled at the worst by ignorant adventurers, or at the best by men having no valid claim to the title of specialist is in these institutions reduced to the lowest possible point. It is not less to the interest of the poor, the public, and the profession, as well as of progress in medical science that professors of specialism should present ample guarantees of their claims to recognition and distinction; and these guarantees are not provided under the conditions which exist at the great majority of special hospitals.

I am, Sir, yours truly,  
Cavendish Square,  
December 7th, 1904.  
HENRY SEWELL.

#### CELLULOID COMBS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—On page 610 of THE MEDICAL PRESS AND CIRCULAR you kindly sent me, you say, in connection with celluloid combs, "unrecognisable as celluloid save to the expert in such matters." May I call your



attention to a method of detection which occurred to me, and which is as simple as I believe it to be infallible: Heat a metal skewer in a candle flame, touch the comb with it, and smell the fumes. If the article is tortoiseshell, the smell is of burnt bone, familiar in the horse-shoeing forge. If it is celluloid, the smell is sweet and camphoraceous.

If you try this method you will at once perceive the difference. If it is done on the inside surface of the comb, no disfigurement results.

I am, sir, yours truly,

HAROLD NUTTALL, M.A., M.D.

Bryn-y-Craig, Conway Road, Colwyn Bay,  
December 7th, 1904.

### Obituary.

JOHN KENNEDY, M.D.R.U.I., M.Ch.

THE death is announced, in his 66th year, of Dr. John Kennedy, of Farnham Place, Old Trafford. Dr. Kennedy took his degree of Doctor of Medicine in the Queen's University of Ireland exactly forty years ago, and two years later he qualified as M.Ch. He was one of the oldest and most respected members of the medical profession in Manchester.

EDWARD BATEMAN HECTOR, M.D. EDIN.

WE regret to announce the death of Dr. Edward B. Hector, of Castle-Douglas, who died suddenly on the 2nd inst. He returned from a visit about four o'clock, and a few hours later was found in a state of collapse, and expired soon afterwards. The deceased, a native of Montrose, took his M.B.C.M. Edin. degree in 1883, and M.D. in 1902. Dr. Hector had an extensive local practice, and was medical officer for the parishes of Balmaghie and Parton. His wife, a daughter of Dr. Munro, Moffat, died last year.

WILLIAM G. VAUDREY LUSH, M.D. LOND.,  
F.R.C.P. LOND.

DR. W. G. VAUDREY LUSH, physician at the Dorset County Hospital, died at Weymouth, on December 7th. He had just addressed a meeting of the committee at the hospital when he fell from his chair and expired. Dr. Lush, who took an M.B. degree with a treble first class in 1865, and that of doctor of medicine at London University in the following year, was one of the best-known practitioners in Dorset. He was an active Churchman and county secretary of the Queen Victoria Clergy Fund, and leaves behind him a large circle of friends and acquaintances. He made numerous contributions to medical literature.

CHARLES WILLIAM CHALDECOTT, M.R.C.S. ENG.,  
L.S.A.

WITH much regret we announce the death of Mr. Charles William Chaldecott, of Dorking, Surrey, on November 5, at the age of seventy-six. He received his professional training at St. Thomas's Hospital, where he studied from 1848 to 1851, and distinguished himself much as a student. In 1851 he became qualified as M.R.C.S. Eng., and L.S.A., and took over his father's practice at Dorking. Until his retirement in 1901, no less a period than fifty years, Mr. Chaldecott was in the active pursuit of a large practice. He was twice married, his first wife, who died in 1866, being a sister of the late Sir John Simon, and he leaves a family of nine sons and daughters. In him the profession has lost one of the typical representatives of the old school of honourable medical men of high social standing.

DR. D. ASTLEY GRESSWELL.

BY telegram we have been informed of the death of Dr. D. Astley Gresswell on December 10th, at Melbourne. The deceased was Chief Health Officer for the Colony of Victoria, an appointment he has held some fifteen years, during which he has inaugurated far-reaching sanitary improvements in the city of Melbourne and throughout the colony. He was an indefatigable worker, and his patience and persevering industry were well known. He is the author of a work on "Scarlatina" and joint author with his brother, Mr. G. Gresswell, of a treatise on "Comparative Pathology." He took the degree of M.B. Oxon., in 1881, and M.D. of the same

university in 1889. He was also a member of the Royal College of Surgeons of England, J.P. for Victoria, and was much appreciated as a genial, cultured man.

### DEATHS OF EMINENT FOREIGN MEDICAL MEN.

THE deaths of the following eminent foreign medical men are announced:—Dr. W. Massen, professor of midwifery and gynaecology in the University of Odessa. Dr. A. Sanchez Herrero, professor of clinical medicine in the University of Madrid. Dr. K. von Stellwag, formerly professor of ophthalmology in the University of Vienna. Dr. Albert Reeder v. Schellmann, formerly professor of dermatology in Vienna, at the age of seventy-eight years. Dr. Alfred Zimmermann, a Vienna staff surgeon, who was a very experienced operator, especially in abdominal cases. His death was due to septic poisoning. He was only thirty-nine years of age. Dr. Redtenbacher, one of the medical officers of the Vienna General Hospital. Dr. Hugo Mittenszweig, one of the editors of the Berlin *Zeitschrift für Medicinalbeamte*. Dr. Robert Langerhans, *privat-docent* of pathological anatomy in the University of Berlin. Dr. Joaquim Pereira da Cunha, professor of ophthalmology in the University of Rio de Janeiro.

### Literature.

#### TRANSACTIONS OF THE MEDICO-LEGAL SOCIETY. (a)

THE constantly growing importance of the relations between the two great professions of law and medicine has recently been marked by the foundation of the Medico-Legal Society. The first volume of the proceedings has just been published, and contains some papers of great interest. One burning question appears continually throughout its pages, namely, the subject of coroners' inquests. Mr. Troutbeck gives a very interesting paper on "Inquest Juries," in which he goes very fully into their advantages and defects; and there is no doubt that if there were no other advantage except that "the jury constitutes the only practical check on the coroner," it would be a mistake to try to abolish them.

Dr. Littlejohn gives a valuable paper on "Medico-Legal Post-mortem Examinations," which necessarily deals with the same subject. Undoubtedly the medical profession feels that there is too much uncertainty, and perhaps laxity, in the matter of having autopsies in cases of sudden death; but this is owing to the present state of the law, and it is one of the functions of such societies as this, to help to educate public opinion in the matter, as it is only in this way that reform can be expected. But Dr. Littlejohn emphasises one point that is too often forgotten by teachers and students alike—that no subject in the curriculum is more neglected than medical jurisprudence. This ought not to be the case, as no practitioner is able to be certain that he will not at some moment find himself involved in a case of the first importance.

Mr. Wellesley Orr gives a short paper on "Cremation," showing its steady if somewhat slow increase in popularity. One of the great arguments against cremation has, of course, been that destruction of the body may facilitate crime, but Mr. Orr enumerates the precautions taken by the Cremation Society to guard against this; but even so it will take time to educate the public up to realising this, and till then there is always a risk that a man might be emboldened to commit a crime if he knew that the body was to be cremated.

The price of the volume is rather excessive, and the Society would be wise if they could see their way to lowering it, so as to increase the circulation.

#### ASTHMA IN RELATION TO THE NOSE. (b)

The greater part of this little volume consists of an

(a) "Transactions of the Medico-Legal Society for the years 1902, 1903, 1904. London: Baillière, Tindall, and Cox, 7s. 6d. 1904.

(b) "Asthma in Relation to the Nose." By Alexander Francis M.B., B.C. Cantab. Pp. 136. Price 5s. net. London: Adlard and Son, 1903.

appendix containing brief notes of over 400 cases of asthma treated by the author's method, and we can at least say that they supply ample *prima facie* evidence of the value of the procedure which he has discovered. The opening chapters of the book deal with the etiology of the disease, Dr. Francis' view being that it is due to spasm of the bronchial muscles induced by reflex action. The question of the relation of nasal lesions to asthma is fully dealt with, the conclusion being that asthma is not directly due to any mechanical obstruction of the nasal passages, and only rarely to reflex nasal irritation. The novel conception led up to is, that in asthma a morbid connection subsists between some part of the nose and the respiratory centre, whereby that centre is thrown into a state of unstable equilibrium. This theory has been arrived at empirically, by the observation of the effect of cauterising the nasal septum, which is the plan of treatment advised. Contrary to the usual opinion, the author holds that the prognosis is in inverse ratio to the extent of the nasal lesion—polypus cases being the least, and those in which the nose appears healthy the most, hopeful. It is impossible to express an opinion on the value of the treatment until further trial has been made, but we feel strongly that Dr. Francis offers cogent reasons for the faith that is in him, and if his treatment yields even half as good results in the hands of others as it has done in his, he need not feel that his book has been written in vain.

#### THOMSON AND MILES' MANUAL OF SURGERY. (a)

THE second volume of this work, dealing with "Regional Surgery," maintains the excellent characters of the first volume which we recently had the pleasure of reviewing. One of the best chapters is that on the "Kidney and Ureter" (Chap. xxxii); in it the more recent methods of ascertaining the condition of the kidneys, such as catheterisation of the ureters and cryoscopy, are fully gone into. Taking the book as a whole, there are but few statements with which we have to find fault. One such, however, occurs in Chapter xxxi on "The Rectum and Anus," where, in dealing with carcinoma of the rectum, the authors say, "Pain is a variable symptom, but is usually present, and in some cases is agonising." This is a statement which, especially in a book intended for students, we cannot help thinking to be rather unfortunate. We too frequently see carcinomata of the rectum that have reached the inoperable stage, and in which the patient has never suffered pain. If the student has been led to regard pain as a usual symptom, its absence may cause him, as a practitioner, to neglect to make a digital examination of the rectum until the disease has progressed too far for complete removal.

The book concludes with an appendix on anaesthetics. The authors prefer a chloroform and ether mixture, containing one part of the former to two of the latter for children under five and adults over sixty; but in vigorous adults of from eighteen to forty-five they say it is advisable to induce anaesthesia with some other anaesthetic, owing to the risk during the struggling stage.

The illustrations are not so numerous as in the first volume, but the majority are exceedingly good. One could not wish for better illustrations than those showing the various forms of hare lip. We can congratulate the authors on the way they have completed their work. It is one which we can strongly recommend to the practitioner and senior student.

#### DEVELOPMENT AND ANATOMY OF THE PROSTATE GLAND. (b)

THE author, in his preface, states that this is not a

(a) "Manual of Surgery." By Alexis Thomson, M.D., F.R.C.S. Ed., and Alexander Miles, M.D., F.R.C.S. Ed. Vol. II.—Regional Surgery. Illustrated with 156 wood engravings. Pp. 723. Edinburgh: Young J. Pentland, 1904.

(b) "The Development and Anatomy of the Prostate Gland, together with an Account of its Injuries and Diseases, and their Surgical Treatment." By W. G. Richardson, M.B., B.S., F.R.C.S. Pp. 131. 46 Illustrations. London: J. and A. Churchill, 1904. Price, 10s. 6d.

treatise upon the prostate and its diseases, but is an essay which was submitted by him for the Health Scholarship in the University of Durham. The first fifty pages are devoted to a very excellent account of the anatomy and comparative anatomy of the prostate gland. The remainder of the volume consists of a description of chronic enlargement of the prostate, its surgical treatment and the complications following operation, together with a table of thirty-six cases of prostatectomy.

There is no doubt that this essay deserved the prize which was awarded, and we can heartily recommend it to surgeons who are interested in prostatic surgery. The manner of treating the subject is both interesting and instructive. The illustrations are a remarkable feature and very valuable, whilst the publishers deserve great credit for the way in which the book has been turned out.

#### THE PURIN BODIES OF FOODSTUFFS. (c)

THIS work is a re-issue of that given to the medical world in 1902 by Dr. Hall. The previous issue has been revised, partially re-written, the results of recent investigations included, together with new estimations, and the literature on the subject has been brought up to date. A chapter on the action of drugs upon purin excretion is also added.

This work is the result of the desire of Dr. Walker Hall to further investigate "the action of purin bodies and their metabolism, and to discover some means whereby the early pathological changes in certain metabolic disorders may be detected." To effect this, the author first estimated the purin bodies present in some of the commoner articles of food, and then observed their specific effects upon human and animal metabolic processes, when injected subcutaneously, or when introduced *per os*.

Purin bodies, or alloxuric bodies, are substances constructed on the base  $C_5N_4$ , the nucleus  $C_5N_4$  having been termed "purin" by Emil Fischer. The most common purin bodies are hypoxanthin, xanthin, uric acid, guanin, adenin, caffein, and theobromin. Altogether, about twelve of these bodies are known to exist in nature, but 146 have been synthetically prepared in the laboratory. After briefly explaining the composition and properties of the food purins, the author explains the various methods that have been suggested for the extraction and estimation of purins, one of the main difficulties being to find an efficient process for removing the proteids. The author gives a detailed description of the method he employed, and relates the experiments he made to show the accuracy of the process. The quantities of purins in meat foods, vegetable foods, and beverages having been enumerated, he devotes a chapter to the action of food purins on the alimentary and circulatory systems, and also on the respiratory, genito-urinary, nervous, and muscular systems. Dr. Hall then gives us records of experiments, made upon himself and others, to ascertain the comparative effect of purin bodies upon the production of carbon dioxide, and of experiments showing the effect of daily injections of purin bodies in rabbits.

A chapter is devoted to "The Fate of Food Purins in the Body," and one on "The Role of Purin Bodies in Morbid Conditions," where the author shows the necessity for experiments affording information regarding the metabolism of the children of gouty parents and its alterations during their growth. May we hope that many medical men who desire to help forward medical research will assist those workers, like Dr. Hall, who are striving so hard to elucidate the abstruse subject of gout?

The author tersely remarks, when discussing the action of drugs upon the elimination of purin bodies that in gout and allied disorders "Fashion has decreed the use of numerous drugs in the active and prophylactic

(c) "The Purin Bodies of Foodstuffs, and the Role of Uric Acid in Health and Disease." By J. Walker Hall, M.D. Second Edition. Revised. Pp. 201 and xiii, with 29 Tables and Illustrations. London: Sherratt and Hughes, 1903.

lactic treatment of these conditions, and the value of each medicament has been measured in terms of its solvent powers for uric acid in the test tube, quite regardless of the fact that it could not be safely introduced into the blood in sufficient quantities to exercise its soluting properties." The author says that Luff's belief that sodium salicylate is contra-indicated in gout deserves wider appreciation, and, again, "In our present state of knowledge, one fact stands out prominently, *viz.*, that we have not a drug that can be administered in sufficient quantities to affect the circulation of urates in the tissues."

Altogether this book is a straightforward account of the present state of knowledge on the subject of purin bodies, and the author must be congratulated on the comparatively successful issues of his experiments and upon the valuable assistance his work has afforded to medicine; but there are one or two minor details we should like to point out—for example, on page 34, the author is a bit ambiguous. Does he mean that the residue was boiled several times with acidulated water? Again, in describing the estimation of sulphates on page 197, the author omits to say that the barium chloride solution should be added boiling, and also that after that addition the urine containing the precipitate ought to be boiled for fifteen minutes. The above omissions are obviously due to the proof sheets being perhaps hurriedly revised, evidence of which appears several times through the book. Superfluous "ands" occur in two places, an "of" would not be out of place between "excess" and "phosphotungstic" on page 32, Kjeldahne is given for Kjeldahl, stop for stop-cock, nervour for nervous, and, finally, the table of atomic weights, which is so up to date that it includes radium (while excluding sulphur, calcium, and several others), contains four elements spelt in ways that are new to us—*viz.*, borium for boron, molybdium for molybdenum, silica for silicon, and tungstium for tungsten. Lead is also placed among elements commencing with B. The author uses the words "solute" and "soluting" for "dissolve" and "dissolving." There is, however, one serious blunder, and that is on page 197, where we gather that the author incinerates the preparation formed by adding sulphuric acid to the wash water from his barium sulphate-precipitate, together with the latter precipitate. Surely this cannot be what Dr. Hall intends, and multiplying the weight of  $\text{BaO}$  by 0.3433 will give  $\text{SO}_3$ , and not sulphuric acid. Except for the few typographical errors, this little book is admirable in every respect, and we wish the author many further successes in the continuance of his researches on the subject under consideration, and we hope members of the profession will seriously consider the results of Dr. Hall's experiments, they being so vitally important in reference to this all too common disorder.

#### TOLDT ON ANATOMY.(a)

We have received from Messrs. Rebman, Parts IV and V of this most excellent atlas. Part IV deals with the subject of "Splanchnology," and contains nearly three-hundred illustrations to illustrate the anatomy and histology of the various organs of the body. The system of illustrating adopted in former volumes is continued, as a rule with good results. There are special sections devoted to the male and female reproductive organs, and though these are both good so far as they go, we should like the latter to have been more fully dealt with, especially in view of the manner in which it is neglected in most anatomical works. Part V deals with "Angiology," and is, perhaps, the finest part as yet published. It contains something like 200 illustrations, the majority of which are full-page, and, in almost all, the vessels are shown in colours.

(a) "An Atlas of Human Anatomy, for Students and Physicians" by Carl Toldt, M.D., Professor of Anatomy in the University of Vienna, assisted by Professor A. D. Rosa, M.D. Translated from the Third German Edition by M. Eden Paul, M.D. Brux. Fourth Section, Splanchnology. London and New York: Rebman, Limited, 1904.

The illustrations of the pelvic vessels are good but again might be more numerous. The Part concludes with a description of the lymphatic system. The Atlas has well fulfilled the expectations that were formed of it on the appearance of its first part, and we can thoroughly recommend it. One part remains for publication, and will deal with the subject of Neurology and with the Organs of the Senses.

#### BACTERIOLOGY OF MILK. (a)

It was once remarked by a well-known bacteriologist that searching for specific bacteria in milk was like looking for nails in a ten-acre grass field, with the aid of a pair of badly-suited spectacles. Considering that a cubic centimetre of milk may contain over 150,000,000 micro-organisms, this analogy is not exaggerated, and even with the many methods at present at our disposal, the bacteriology of milk is a very difficult matter indeed. The authors of this valuable book, therefore, deserve the hearty thanks of the medical profession, of bacteriologists, of sanitary inspectors, and the public generally. The subject bristles with difficulties, for when we have overcome the difficulty of examining a milk bacteriologically, we are astounded at the great possibilities of danger that may lurk in this important and universal article of diet, and to lessen, if not to prevent, these dangers appears to need stringent legislation. These and many other considerations are ably discussed in this work, which the authors believe to be "the first occasion on which an attempt has been made to deal in a systematic manner with the bacteriology of milk."

As an example of the progress of the subject, take the question of acid-fast bacilli. Not so many years ago we fondly hoped that the Ziehl-Neelsen method of staining excluded all organisms except the *B. tuberculosis*, *B. lepræ*, and the *Smegma bacillus*, but now, thanks to the researches of Koch, Petri, Korn, and others, we find that other organisms have been found in milk and milk products, having originally occurred in the grass, dust, &c., which also retain their colour when stained by this method, and the authors are constrained to insist on "the importance of the inoculation test being applied to all acid-fast and tubercle-like organisms detected in milk or butter." We may remark in passing that the book contains some beautiful coloured plates, illustrating the appearances of growths of these acid-fast bacilli. As at the time this book was published the Royal Commission on Tuberculosis had not issued their interim report, the authors take up the provisional attitude "that tuberculosis in all animals is generically one and the same disease, but that it differs in various ways in different animals, and according to the strain and virulence of the infecting bacillus."

The authors in considering the question of a practical standard of the number of organisms which might be permitted in milk, divide the conditions affecting the number of bacteria into three divisions: The influence of time, the influence of temperature, and the inter-relationship of different species of bacteria and the germicidal effect of the milk. Anyone reading the matter included under the first two headings must be forced to the conclusion that milk ought to be refrigerated as soon as it is drawn. After showing how milk is theoretically an almost ideal medium for both saprophytic and parasitic bacteria, the writers give, on page 20, a table compiled from the experiments of Backhaus, of Königsberg, which shows the possible extent of contamination of milk from various sources in the interval between the milking of the cow and its ingestion by the public.

In the chapter relating to the "Examination of Air and Water in Relation to the Milk Supply," we find

(a) "Bacteriology of Milk." By Harold Swithinbank and George Newman, M.D., F.R.S.E., D.P.H. With special chapters, also by Dr. Newman, on the Spread of Disease by Milk and the Control of the Milk Supply. With 83 plates, 35 text illustrations, and 4 maps and charts. Pp. 606 and xx. Price 25s. net. London: John Murray, 1903.

one or two little details in which we must differ from the authors. Many people will disagree with the statement that "*B. coli* is a most accurate measure of intestinal pollution," and an enumeration of this bacillus is certainly a wearisome and unsatisfactory way of judging the extent of pollution. A note to the effect that a partial chemical examination of the water would be most valuable, probably more so than the tedious bacteriological examination, would not perhaps be out of place. We might venture to point out that the percentage of salts in milk given on page 4, *viz.*, 0.7, is lower than it should be, *viz.*, not lower than 0.75.

Twenty appendices dealing with Acts affecting milk, regulations in force in private companies and in various districts and on kindred subjects, close a volume which is well illustrated, well written, singularly free from errors, and which must be considered, in the present state of our knowledge, the standard book on the subject.

#### REPORT OF THE REGISTRAR-GENERAL, IRELAND. (a)

THE concentrated information contained in the summaries compiled for the pages of this "Supplement" makes it, of course, a most interesting and instructive volume of reference. The causes of death which have been most profusely discussed of recent years in this country are, we believe, *alcoholism*, *cancer*, and *phthisis*. On this account the following extracts will be of the greatest interest to all readers:—(1) "During the decade, 1,601 deaths were attributed to the effects of alcohol; of these 1,601 persons, 1,306 were males and 295 were females. Of the total deaths, 421 were registered as having been caused by delirium tremens (388 males and 33 females); and 1,180 persons fell victims to chronic alcoholism (318 males and 262 females)." (2) "According to the system which obtained during the ten years now the subject of review, the deaths classified under the head of cancer, malignant disease, include those deaths which were certified as carcinoma, scirrhus, epithelioma, rodent ulcer, &c., and sarcoma. The total number of these deaths recorded in the decade is 24,435, of which 11,062 were of males and 13,373 were of females. In the preceding decade the number of deaths from cancer in Ireland was 20,036, *viz.*, 8,964 males and 11,072 females, and in the decade which ended with the year 1880, the total number of deaths recorded was 17,790 (7,789 males, and 10,001 females). The average annual rate per 10,000 of the population represented by the deaths from cancer, malignant disease, which for the decade 1871-80, was 3.4 per 10,000 of the mean population, rose to 4.1 for the following ten years, and to 5.3 for the decennium ending with the year 1900. . . . The deaths of 11,062 males and 13,373 females were recorded, these numbers are equal respectively to the average annual rate of 4.90 and 5.76 per 10,000 of the mean population of males and females in Ireland." Omitting the cases under 25 years of age registered as deaths from cancer, "only 294 (156 males and 138 females) during the decennium," . . . "and basing the calculations on the estimated mean number of persons aged 25 years and upwards in the population, it is found that the deaths from cancer and malignant disease during the decade were equal to an average rate of 11.1 per 10,000 persons, against an average rate of 8.8 per 10,000 for the preceding ten years, and a rate of 7.3 per 10,000 for the ten years 1871-80, so that in the ten years 1891-1900, allowing for the decrease in the population, the registered mortality under the head of persons aged 20 years and upwards was 52 per cent. in excess of that for the ten years 1871-80, and 26 per cent. in excess of that for the decade 1881-90. The average rates for the sexes taken separately were: In ten years ending with 1880, males 6.7 per 10,000

(a) "Supplement to the Thirty-seventh Report of the Registrar-General of Marriages, Births, and Deaths in Ireland, containing Decennial Summaries of the Returns of Marriages, Births, Deaths and Causes of Death in Ireland for the years 1891-1900." Dublin: E. Ponsonby; London: Eyre and Spottiswoode; Edinburgh: Oliver and Boyd. 1904.

males aged 25 years and upwards in the population: females 7.8 per 10,000; in the ten years 1881-90 males 8.2, females 9.3; and in the decade 1891-1900 males 10.4, females 11.7 per 10,000." (3) "In the classification followed during the decade 1891-1900 deaths from tuberculosis were distributed under four heads, namely, 'Phthisis,' 'Tuberculous Meningitis (acute hydrocephalus), 'Tabes Mesenterica,' and 'Other Forms of Tuberculosis. Scrofula.' . . . The tuberculous death-rate has risen in Ireland since the first of the decades [1871-80] covered by the above statement—a fact which goes to show that the sanitary and other measures which have been undertaken for the improvement of the public health have not as yet arrested the ravages of this formidable disease." These extracts form ample proof that there is full scope for the future labours of the moralist, the sanitarian, and the therapist in the opening era of the democratic section of Irish history.

#### PARLIAMENTARY REPRESENTATION OF THE UNIVERSITIES OF GLASGOW AND ABERDEEN

AT a meeting of the Graduates of the above Universities held at the Holborn Restaurant, London, on Thursday, the 8th inst., the Rev. Canon D. Reith, M.A. in the chair, to hear an address from Professor William R. Smith, M.D., it was subsequently moved by Mr. T. B. Browning, M.A., seconded by Dr. J. Nelson Matthews, and carried, "That this meeting of graduates of Glasgow and Aberdeen Universities cordially endorse the candidature of Prof. William R. Smith, M.D., and pledge itself to use its best endeavours to secure his return." In supporting the resolution, Prof. W. J. Simpson, M.D., F.R.C.P., and Dr. J. Ford Anderson pointed out the totally inadequate representation of the Medical profession in Parliament, that this seat offered one of the very few of the opportunities for returning a medical man to Parliament, and the difficulty always experienced in finding a medical candidate; they insisted upon the reflection which would be cast upon the graduates if they had to seek a representative from another University as was suggested, and urged that in Professor Smith, who had attained a prominent position in Preventive Medicine and had great public experience, they had a candidate whom it was most desirable should be elected. Meetings of the medical graduates have also been held in Sheffield, Blackburn, and Lincoln, at which a similar resolution was passed.

#### Medical News.

##### The London Polyclinic Dinner.

THE sixth annual dinner of the London Polyclinic was held on the 7th instant at the Trocadero Restaurant under the genial presidency of Dr. C. Theodore Williams. It was announced that Mr. Jonathan Hutchinson, one of the founders of this flourishing and valuable institution, was unfortunately unable to be present on account of indisposition. Another founder was present, however, in the person of Dr. Fletcher Little. A large company, including many ladies, appeared to enter thoroughly into the swing of a capital evening's entertainment. Dr. Theodore Williams made a capital speech. Among other things he spoke of the post-graduate courses that formerly sent the student all over London in search of hospitals for this, that, and the other speciality, until he arrived finally at Bedlam in an exhausted condition and more fitted to be an inmate than a mere visitor. Captain Haward Punch, the energetic secretary, delivered an amusing and apposite speech. Mr. Mayo Robson responded for the Polyclinic and Mrs. Scharlieb for "The Ladies." Several speakers dwelt on the present state of affairs in this undertaking as most promising of future prosperity.

##### Liverpool School of Tropical Medicine.

LAST week a deputation from the Liverpool School of Tropical Medicine waited on the Colonial Secretary, Mr. Lyttelton, for the purpose of bringing before his notice the despatch of a large medical and scientific expedition to West Africa for the purpose of helping

to promote the work of stamping out tropical diseases. Sir Alfred L. Jones introduced the deputation, which consisted of the following gentlemen:—Professor Boyce, F.R.S., Sir Ralph Moor, K.C.M.G., Colonel Giles (India Medical Service), Dr. Evans, Dr. M'Connell (Canada), Dr. Jollerton Thomas (Canada), Dr. Anton Baniel (Austria), Dr. Clarke, and Mr. A. H. Milne (hon. secretary, Liverpool Tropical School), Mr. John Holt, Mr. J. Irvine, Mr. J. Strafford, Mr. Haggart, and Mr. B. Caarten.

#### Heavy Damages for Assault on a Medical Man.

DR. A. D. GRIFFITHS was last week awarded £500 damages at Swansea yesterday for an assault committed by George Faithfull, an electrician, while Dr. Griffiths was attending the defendant's wife. The assault was aggravated by a charge reflecting on the doctor's character.

#### Sympathy with Dr. Arthur Griffiths, Bridgend.

At a largely-attended meeting of the South Wales and Monmouthshire Branch of the British Medical Association, held at Carmarthen, the following resolution was unanimously passed:—"That the members of the South Wales and Monmouthshire Branch of the British Medical Association desire to convey to Dr. Arthur Griffiths their sincere sympathy with him in the painful position in which he was recently placed by the unfounded charge laid against him, and their congratulations on his having so completely justified their trust in his unblemished character." This motion was proposed in the name of the President of the Branch by Mr. Tatham Thompson (Cardiff), seconded by Dr. Evan Jones (Aberdare), and supported by Dr. Cresswell (Dowlais) and Dr. Lynn Thomas (Cardiff).

#### Nottingham Medico-Chirurgical Society.

THE Nottingham Medico-Chirurgical Society held its annual dinner at the George Hotel, last week, under the presidency of Dr. H. J. Neilson. The Mayor of the City (Alderman Joseph Bright) was the guest of the evening, and Councillor Dr. T. J. Daybell attended in a dual capacity as Sheriff, and as a member of the organisation, the company numbering about 70. The toast of "The Society" was submitted by the President of the Leicester Medical Society (Dr. R. C. Stewart), and acknowledged by the President. The Vice-President (Dr. J. F. Blurton) proposed "The Visitors and the Mayor of Nottingham," and "The President of the Derby Medical Society" (Dr. F. R. Cassidy).

#### Trinity College, Dublin.

THE following candidates passed the Final Examination in Midwifery:—Benjamin Johnson, Arthur A. M'Neight, John Cunningham, Lily A. Baker, William J. Powell, William R. Galwey and William Nunan (equal), Thomas J. T. Wilmot, Eva J. Jellett, James H. C. Thompson, Henry E. M'Creedy, Thomas Creaser, George McG. Millar, William Hassard, Carlile Kelly, and Alfred G. Alexander.

#### Chemists' Exhibition.

COVENT Garden Theatre has been selected as the site for the next annual Chemists' Exhibition, organised by the *British and Colonial Druggist*. The same building, it may be remembered, was used for the exhibition some seven years ago. The Exhibition will be open from March 13th, 1905, to March 17th, inclusive.

#### Hospital Sunday Fund.

THE annual general meeting of the Metropolitan Hospital Sunday Fund will be held at the Mansion House on Friday next at 2.30.

#### Royal College of Surgeons of England.

At the ordinary meeting of the Council of the College held on Thursday last, Mr. John Tweedy, F.R.C.S., President, in the Chair, the death of Professor Tillaux of Paris, an honorary Fellow of the College was reported. Diplomas of Fellowship were issued to 29 candidates, and diplomas in Dental Surgery to 40 candidates. In accordance with the recommendation of the Board of Examiners in Dental Surgery, it was decided to publish a syllabus defining the scope of the examination in anatomy, physiology, and surgery which candidates

for the licence in Dental surgery are required to pass. It was also decided that this examination should be held three times instead of twice during the year. In reference to a communication from the Board of Education asking the opinion of the College upon proposals framed by the consultative committee of the Board for a system of school certificates, a resolution was adopted expressing general approval of the scheme. Mr. Bernard Pitts, F.R.C.S., surgeon to St. Thomas's Hospital, was re-elected a member of the Court of Examiners. The resolutions carried at the annual meeting of Fellows and Members on the 17th ultimo were reported to the Council. The Liverpool Stanley Hospital was added to the list of General Hospitals recognised for the purposes of study by candidates for the Diploma of the college. It was also determined to add the Municipal College, Grimsby, to the list of institutions recognised for instruction in chemistry, physics, and practical chemistry. A report was received from the laboratories committee stating that, during the three months ending December 1st, 7,548 doses of diphtheria antitoxin, each containing 3,000 units, have been supplied to the hospitals of the Metropolitan Asylums Board.

THE following members of the Royal College of Surgeons of England were admitted to the Fellowship of the College at the meeting of the Council on the 8th instant, Mr. John Tweedy, the president, in the chair:—John Arthur Hayward, M.D. London, St. Bartholomew's and Oxford; Cecil Edward Marriott, M.B. Cambridge, Cambridge and University College, London; Francis Joseph Maria Hasslacher, M.B. London, King's College, London; John Clay, M.B. Durham, Durham; Herbert Dean Pollard, M.B. London, London; Donald Johnstone McGavin, M.D. London, Birmingham and London; Charles Ferrier Walters, L.R.C.P. London, Bristol; Reginald Cheyne Elmslie, M.B. London, St. Bartholomew's; George Ernest Waugh, M.B. London, Cambridge and University College, London; William Francis Harriott Coke, L.R.C.P. London, St. George's; Ernest Rock Carling, M.B. London, Westminster; Somerville Hastings, M.B. London, Middlesex; Hugh Davies-Colley, M.B. Cambridge, Cambridge and Guy's; Harold Upcott, L.R.C.P. London, St. Thomas's; Joseph Ebenezer Adams, L.R.C.P. London, St. Thomas's; Harold Ashton Lyth, M.B. London, University College; London; William Arthur Rees, M.B. London, Middlesex; Arthur Robertson Brailey, L.R.C.P. London, Cambridge and Guy's; Norman Carpmael, L.R.C.P. London, St. Thomas's; Charles Bernard Goulden, M.B. Cambridge, Cambridge and Middlesex; Walter Lidwel Harnett, M.B. Cambridge, Cambridge and St. Thomas's; Archibald Trevor Moon, L.R.C.P. London, London; Kenneth Black, L.R.C.P. London, Guy's; Thomas Jefferson Faulder, L.R.C.P. London, Cambridge and St. Bartholomew's; Neville Ivens Spriggs, M.B. London, Guy's; Frederick Henry Parker, M.B. Cambridge, Cambridge and Guy's. The following, not being members of the College, were also admitted Fellows: Robert James Ferguson, M.D.R.U.I., Belfast; Angus McNab, M.B. Edinburgh, New Zealand and Edinburgh; Herbert Bell Tawse, M.B. Aberdeen, Aberdeen and King's College, London.

ON Saturday, the 10th instant, the employés of the united firms of Messrs. Odhams Limited, and Southwood, Smith and Co., Limited, gave their annual dinner at the King's Hall, Holborn Restaurant, London. Some capital speeches were made by the Chairman, W. J. B. Odhams, Esq., and Messrs. Elias, Moir, Lathbury, and Filson Young. The proceedings were varied with an excellent programme of glees and songs. Our readers will be familiar with the name of Odhams Limited, as printers of the *MEDICAL PRESS AND CIRCULAR* for many years past.

THE annual meeting of the Dublin branch of the National Association for the Prevention of Tuberculosis will be held in the Royal College of Physicians this afternoon (Wednesday) at 4.30 p.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," "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.

**CORRECTORS** 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 offices, 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.

**DR. SCHREIB (Algiers).**—Will receive a private note.

### INSOMNIA.

**Visitor:** And what is your husband's complaint, Mrs. Green? **Mrs. Green:** The doctor says it's Insomnia, ma'am; but Bill thinks if 'e could only sleep o' nights 'e'd get over it.

### IN THE APPENDIX.

At a recent dinner the following story was told: "At the same time of King Edward's recovery from appendicitis, thanksgiving services were held all over the British dominions. The services were concluded at a certain church by the singing of a well-known hymn, which happened to be in the back portion of the book. 'Let us close the service,' the rector said, 'by singing the hymn, 'Peace Perfect Peace—in the appendix.'"*—Texas Medical News.*

**KIDDERMINSTER.**—A proper apparatus is needed to prepare instruments and dressings for surgical use on a large scale. Any competent practitioner, however, who is well-grounded in the principles of aseptic surgery, can do all the sterilising wanted for an occasional surgical operation by extempore methods. A small saucopan will serve to sterilise a scalpel, a pair of scissors, dressing forceps, pressure forceps, and needles and thread. With this simple means and some wool pads that can be bought ready sterilised, a capable man could achieve a great deal of operative work.

**DR. E. KINNSOCK (Vienna).**—Your paper on the "Clinical Value of Radiography in Traumatic Intra-muscular Osteomys" is in hand, and will be published as soon as the necessary illustrations are ready.

**H.E.B. (Liverpool),** is thanked, but the paper is scarcely suitable for our columns.

**DR. WOSSIDLO (Berlin).**—Your paper on the "Development of Diagnosis and Treatment of Urinary Diseases" has been received and is marked for early insertion.

**SALUS POPULI.**—The Medical Officer of Health of the District is undoubtedly the man to whom your patient should apply. If, as unfortunately happens in country districts, he is a rival practitioner, that fact should not be allowed to hinder or affect the discharge of his official sanitary duties. A more desirable state of things would be to discover the functions of Medical Officer of Health and of private practitioner, as the two are incongruous and, as a rule, incompatible.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 14th.

**SOUTH-WEST LONDON MEDICAL SOCIETY** (Bollingbroke Hospital, Wandsworth Common).—8.45 p.m. Paper: Dr. S. Taylor: Errors of Treatment.

**DERMATOLOGICAL SOCIETY OF LONDON** (11 Chandos Street, Cavendish Square, W.).—8.15 p.m. Demonstration of Cases of Interest.

**HUNTERIAN SOCIETY** (London Institution, Finsbury Circus, E.C.)—8.30 p.m. Paper: Dr. G. E. Herman: Leucorrhoea.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Q. Silcock: Clinique. (Surgical.) 5.15 p.m. Dr. L. Guthrie: Mental Overstrain in Childhood.

**CENTRAL LONDON THROAT AND EAR HOSPITAL** (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Dr. Abercrombie: Nose.

THURSDAY, DECEMBER 15th.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Dr. L. Guthrie: Mental Overstrain in Childhood.

**MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST** (7 Fitzroy Square, W.).—5 p.m. Lecture: Mr. H. Barwell: Laryngeal Tuberculosis: its Treatment and Prognosis (Demonstration of cases). (Post-Graduate Course.)

FRIDAY, DECEMBER 16th.

**SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN** (12 Chandos Street, W.).—8.30 p.m. Discussion on Sudden and Unexpected Death in Children (opened by Dr. C. J. Macallister, Liverpool). Dr. J. P. Parkinson, Mr. J. W. Thomson, Mr. A. H. Tubby, and Dr. J. Blumfeld will take part in the Discussion.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration:—Mr. de Frenerville: Anaesthetics.

TUESDAY, DECEMBER 20th.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE** (Tottenham Hospital, N.).—4.30 p.m. Lecture-Demonstration: Mr. de Frenerville: Anaesthetics.

**THERAPEUTICAL SOCIETY** (Apothecaries Hall, E.C.).—4 p.m. Dr. Neslor Tirard: On Some Clinical Observations with new Kamodia. The Secretary will read a paper by John B. Gimlette called "Notes on some Methods employed by Kelantan Malays in the Treatment of Furu or Yaws."

## Vacancies.

**Nottingham General Hospital.**—Assistant House Physician. Salary £100 per annum, with board, lodging, and washing in the Hospital. Applications to E. M. Keely, Secretary.

**Nottingham General Hospital.**—Assistant House Surgeon. Salary £100 per annum, with board, lodging, and washing in the Hospital. Applications to E. M. Keely, Secretary.

**Whitehaven and West Cumberland Infirmary.**—Resident Home Surgeon. Salary £120 per annum, with board and lodging. Applications to Wm. H. Sands, Secretary.

**Cumberland and Westmorland Asylum, Garlands, Carlisle.**—Junior Assistant Medical Officer.—Salary £130 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

**West Sussex County Asylum, Graylingwell, Chichester.**—Junior Assistant Medical Officer. Salary £ 50 per annum, with furnished apartments, board, attendance, &c. Applications to the Medical Superintendent.

**Nottingham City Workhouse Infirmary.**—Junior Resident Medical Officer. Salary £120 per annum, with apartments, board, washing and attendance. Applications to G. Muncester Howdell, Clerk to the Board, Poor-law Offices, Nottingham.

**Jaffray Branch of the General Hospital Gravelly Hill, near Birmingham.**—Resident Medical and Surgical Officer. Salary £150 per annum, with board, residence and washing. Applications to the House-Governor, General Hospital, Birmingham.

## Appointments.

**BANNERMAN, WILLIAM, M.B., C.M. Edin.,** Medical Officer and Public

Vaccinator for the North District of the Cirencester Union.

**CARLE FREDERICK C., M.B. Lond., M.R.C.S.,** Senior Clinical Assistant

to the Throat Hospital, Golden Square, W.

**DAVIES, D. L., M.B., B.S. Lond.,** Certifying Surgeon under the Factory Act for the Wisbech and Walsoken District of the counties of Cambridge and Norfolk.

**DAY, LEIGH, M.B., B.Ch. Oxon.,** Honorary Assistant Surgeon to the Essex and Colchester Hospital.

**DELANEY, K., L.R.C.P.I., L.R.C.S.I.,** Certifying Surgeon under the Factory Act for the Carrick-on-Shannon District of the County of Leitrim.

**DIETMAR, F., M.D. Glasg., D.P.H. Cantab.,** Medical Inspector of the Local Government Board of Scotland.

**EWART, E. W. T., M.B., C.M. Edin.,** Clinical Assistant to the Chelsea Hospital for Women.

**FARQUHARSON, J. MALCOLM, M.B., F.R.C.P. Edin.,** Second Assistant Surgeon to the Ear, Nose, and Throat Department of the Royal Infirmary, Edinburgh.

**HALL, DONALD G., M.A., M.D. Cantab., M.R.C.P. Lond.,** Assistant Physician to the Sussex County Hospital, Brighton.

**JONES, EDWARD T., M.R.C.S. Eng.,** Medical Officer of Health of the Borough of Helston, Cornwall: Medical Officer to the Workhouse and to the No. 1 District, and Public Vaccinator.

**MACLAREN, NORMAN, B.C. Cantab., F.R.C.S. Eng.,** Assistant Surgeon to the Cumberland Infirmary.

**ROGERS, J., L.R.C.P.I.,** Certifying Surgeon under the Factory Act for the Ballyarnon District of the county of Sligo.

**SHAW, W. F. M.B., Ch.B. vict.,** House Surgeon and Resident Obstetric Assistant Surgeon to St. Mary's Hospital, Manchester.

**TENCH, M., M.R.C.S., L.R.C.P. Lond.,** Certifying Surgeon under the Factory Act for the Dunmow District of the county of Essex.

## Births.

**ADDISON.**—On December 8th, at Wican Croft, Northwood, Middlesex, the wife of Christopher Addison, M.D., of a son.

**PENNINGTON.**—On December 8th, at Cariton House, Argyll Road, West Ealing, W., the wife of S. B. Pennington, M.R.C.I., L.R.C.P., of a daughter.

**REYNOLDS.**—On December 9th, at Highercroft, Shepherd's Hill, Highgate, N., the wife of Austin Edward Reynolds, M.R.C.S. Eng., of a son.

## Marriages.

**PHILLIPS—COXON.**—On December 7th, at Hampstead Parish Church, Llewellyn Powell Phillips, M.A., M.D. Camb., M.R.C.S., M.R.C.P. of Kasr-el Ain Hospital, and the School of Medicine, Cairo, Egypt, only son of the late Dr. Jam's Mathias Phillips, of Oxford, to Edith Helen, daughter of the late Alfred Coxon and of Mrs. Coxon, Grindon House, Surbiton.

## Deaths.

**LUSH.**—On December 7th at Dorchester, suddenly whilst attending a meeting at the Dorset County Hospital, William George Vandrey Lush, M.D., F.R.C.S. Lond., F.R.C.S. Eng., of No. 12 Frederick Place, Weymouth.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, DECEMBER 21, 1904.

No. 25.

## Original Communications.

### ADENOMA HÆMORRHAGICA OF THE ENDOMETRIUM. (a)

By WILLIAM ALEXANDER, M.D., F.R.C.S.,  
Honorary Surgeon, Royal Southern Hospital, Liverpool, &c.

It is very strange how frequently students of medicine have to search in vain for assistance from books in regard to conditions that they meet with in their practice, conditions that they have seen with comparative frequency, and that have apparently been overlooked by other observers, or if seen have not been considered of sufficient interest to secure a record. Some conditions seem to be recorded too frequently, others are perhaps mentioned by some old writer, but not a modern one is raised to rescue them from obscurity. Such are the cases I bring before you to-night in the hope that I may obtain more information than I have been able to derive from books:—

CASE I.—In 1899, a lady, æt. 34, consulted me for metrorrhagia of eighteen years' duration. During none of these years she had no bleeding, not even at menstruation. This year of freedom was early in the disease. Like the lady in Scripture, she had consulted many physicians without lasting benefit. She had been cured by an eminent gynecologist, now dead, but the relief was only for two months, when the metrorrhagia appeared as before. She was frequently bed-ridden, and at all times a useless invalid, although she had strong aspirations after a useful and busy life. Oöphorectomy had been recommended quite recently. This she felt inclined to have performed, but her medical attendant on hearing of the proposal warned her against it, telling her that removal of the ovaries was frequently allowed by insanity. Such a possible, or rather probable, result naturally frightened her, and she reluctantly refused that operation, resumed her couch, her bed, and her ergot, without much hope of ever being cured, and with the prospect of spending her life, up to the menopause at any rate, as an invalid under medical supervision. She knew all about it, having had a large experience of medical men and medical subjects. Finding that after a more prolonged trial such a life was intolerable, she, without consulting either her doctor or her relatives, came to the out-patient gynecological clinic at the Royal Southern Hospital. The patient was fairly nourished, but pallid and flabby, the result of repeated hæmorrhages and of her sedentary life. To walk or even slight movements about her room would, he said, bring on the bleeding, and sometimes she had to remain in bed altogether for days. The uterus was slightly enlarged and congested, but there was no sign of malignant disease, and the patient's age did not favour such a serious diagnosis. There were no palpable broids, although the existence of small fibroids was the diagnosis arrived at. The previous history of the disease and its treatment did not permit the hope that

further curetting would be more permanently successful than before, and her wish was to have the bleeding stopped, at any cost but that of her sanity and her life. She had no intention of marrying, but wished to live an active, useful life, and did not mind the loss of any of the child-bearing organs. She was advised to have a vaginal hysterectomy performed. This operation, she was told, was certain to stop the metrorrhagia, and, the ovaries being left behind, was not likely to produce such serious symptoms as were alleged to follow oöphorectomy. After consulting with her friends, she came into the private ward of the Royal Southern Hospital; hysterectomy was successfully performed on July 6th, 1899, and the patient left the hospital well on August 8th, 1899. On opening up the uterus after its removal, we found the mucous membrane replaced by a soft, white, gelatinous-looking substance about one-sixth of an inch thick, spreading up into the Fallopian tubes on each side, where it was specially luxuriant and almost polypoid, becoming scanty below and not so even on the surface. It looked as if the growth was reforming below after having been torn away there by the curette. The uterine walls seemed normal, and there was no induration.



Photograph of interior of Uterus in Case I.

CASE II.—In 1900, a Miss G., æt. 39, was seen by me with Dr. George Johnston, of Liverpool, on account of persistent and profuse metrorrhagia extending over eight years. She was very anæmic, but did not seem to have lost much flesh. She had been curetted about five years ago, not only without lasting benefit, but she said the hæmorrhage had been worse since the curetting. I performed the curetting myself most carefully and thoroughly. Her family history was distinctly phthisical, and the dread of the onset of phthisis that possessed the minds of her relatives and of her medical

(a) Read at a meeting of the British Gynecological Society December 8th, 1904.

attendant was naturally intensified by the hæmorrhage, especially as she had been losing weight. I described my experience with the former case, and the same treatment was readily agreed to both by the patient and her friends, and by Dr. Johnston. On April 5th, 1900, vaginal hysterectomy was performed. The uterus presented exactly the same appearance as in the previous case. The results of the operation were all that could be desired, the anæmia was gradually recovered from, and no signs of phthisis have so far appeared.



Photograph of interior of uterus in Case II.

CASE III.—Miss C., æt. 38, single, had been quite regular and normal as regards menstruation up to five years ago, when she became the subject of frequent uterine hæmorrhages at all times, and sometimes to a great extent. The hæmorrhage was checked at first by ergot. When this failed, curetting was performed, and the hæmorrhage abated for a few months. It then came on again more vigorously than ever, and in the meantime one sister had died from recurrent cancer of the breast, and the second had been recently operated upon for the same disease. The patient was also the subject of a nervous twitching of the muscles of the head and neck, which was made much worse by the hæmorrhage. Marriage and child-bearing were not likely events. She was in the meantime much reduced by the repeated losses of blood. From every point of view it seemed to be desirable to have the uterus removed. This was done on September 18th, 1900. The ovaries were left behind. The patient is now (1904) in excellent health. The uterus presented the same appearance as the other cases.



Photograph of interior of uterus in Case III.

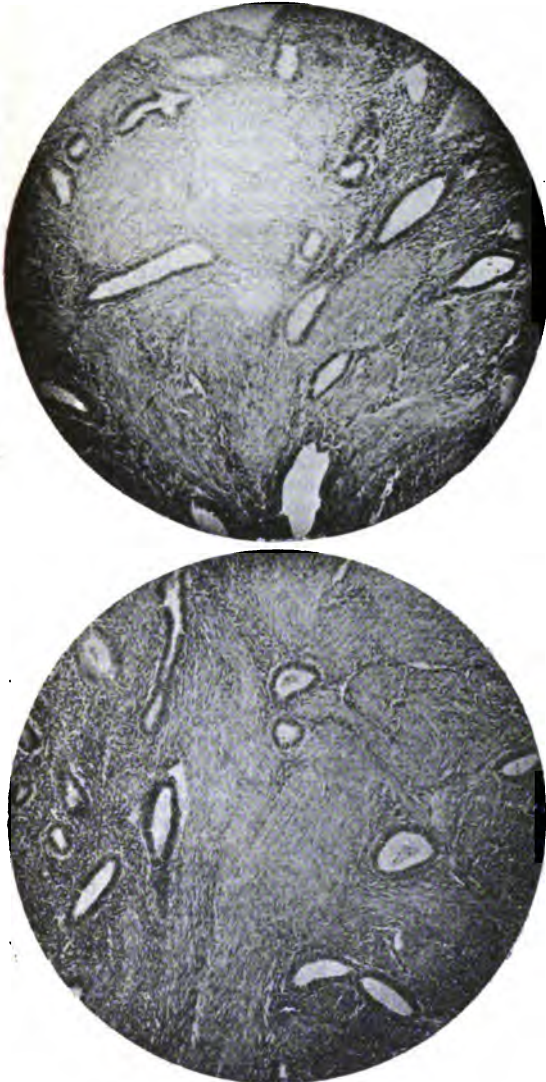
CASE IV.—Mrs. H., æt. 36, married, one child sixteen years ago, from the birth of which she recovered satisfactorily. Ten years ago she had an ovarian tumour removed, and soon afterwards began to suffer from leucorrhœa and occasional metrorrhagia. Neither of these symptoms ever became severe, but they persisted in spite of treatment of different kinds. Twelve months ago she began to suffer pain in the right side of the pelvis, which continued ever since uninfluenced by any drugs, except sedatives. Six months ago dyspareunia set in, and was accompanied by blood-stained, foul-smelling discharge. Patient is cachectic-looking. On examination, the os uteri was found elongated, eroded, and very hard, but not apparently the seat of malignant disease. The canal of the uterus was normal in depth. Microscopical examinations of curettings did not give a decided diagnosis of any kind. Clinically the disease looked so malignant in its nature that removal of the uterus was advised, and was readily agreed to both by the patient and her husband. The operation was performed on November 3rd, 1904. On cutting the uterus open, the pathologist remarked, "The whole endometrium was infiltrated with a whitish fibrous-looking formation that merely thickened the walls of the uterus without altering their contour." It was an exact counterpart of the conditions found in the other cases. On November 29th the patient was discharged, quite well.

CASE V.—Emily E., æt. 41, admitted to hospital November 13th, 1903. She was confined eighteen months ago. Soon after convalescence from the confinement she began to suffer from pain in the lower part of the abdomen and back, and from intermittent attacks of bleeding, which were not amenable to treatment. Two days before admission she had severe hæmorrhage, and was bleeding profusely when admitted to hospital. Ergot was given, and the hæmorrhage stopped. Examination showed an enlarged, eroded anterior os, uterine cavity normal in size. A curetting did not show any growth or irregularity of the uterine wall. As the state of the os was considered suspicious, a small piece of the anterior lip was removed for examination, and a section showed dense fibrous tissue with cystic dilatation of the cervical glands. No evidence of malignancy. She was douched with creolin. Ergot and hydrastis were prescribed. The hæmorrhage continued, and was frequently accompanied by so much pain that nepenthe had to be resorted to. On December 16th, 1903, the os was dilated up to 22, and the cavity thoroughly curetted. The pathologist did not make anything definite out of the curettings, except that the glandular tissue was increased. For a few days she was relieved, when the hæmorrhage began again, and continued at frequent intervals. On January 21st, she had a severe attack of metrorrhagia, accompanied by severe pain in the pelvis. She was evidently losing ground so rapidly that, being convinced that the disease was probably malignant, I advised vaginal hysterectomy, which was performed on January 25th, 1904. The patient made a good recovery, but some troublesome pains in her back continued more or less till May, when she reported herself as quite well. She has not been seen since. The uterine cavity presented an exactly similar appearance to the previous two cases, where a fine, soft gelatinous substance was spread over the surface of the uterine cavity.

It will be seen that the chief symptom in all these cases was persistent hæmorrhage recurring after curetting and after all treatment; not so great as to destroy life, but sufficient to keep up a condition of anæmia and invalidism. The size or shape of the uterus did not differ materially from that of a normal uterus, and the curettings did not present to the pathologist anything abnormal. The glands were, perhaps, more numerous, but nothing more. One had a child sixteen years ago, and another had a child one year and a half ago; the rest were all nulliparous women.

After removal, the uterine cavity presented very distinct and uniform features in a thick, semi-gelatinous, semi-fibrous membrane, running into folds or polypoid masses affecting the whole mucous membrane of the uterus and the beginnings of the Fallopian tubes. Little points of blood appeared here and there in some of the specimens. I am sorry not to be able to show a recent specimen, as hardened specimens become quite different in appearance. I can, however, show slides which will give some idea of the appearance of recent cases.

I have only recently had Case IV. thoroughly examined by Dr. F. Griffith, one of the pathological Fellows at the Thompson Yates Laboratories, Liverpool. He reports the disease to be an adenoma of the endometrium, and the two photo-microscopic lantern slides he has prepared for me will show you at a glance the nature of the change. You will then see how the glandular



Microphotographs showing downgrowths of epithelium.

tissue has dipped down between the bundles of muscular fibres of the wall of the uterus, and it is probably the presence of these downgrowths of adenomatous tissue that produces the hæmorrhage, and hence the disease.

Hysterectomy was successful in all these cases, and a cure resulted in them all. That resource is only to be had recourse to when all well-known methods have failed, and when sufficient time has elapsed. Eighteen years is, however, too large a slice out of a human life to let pass before using curative means.

### A NOTE UPON SOME SUBSTITUTES FOR SILVER NITRATE IN EYE WORK, WITH PARTICULAR REFERENCE TO ARGYROL.

By SYDNEY STEPHENSON, M.B., C.M.,

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NITRATE of silver (or lunar caustic, as it used to be called) has enjoyed for nearly two hundred years a reputation in the treatment of superficial affections of the eye. Its value was recognised by the older writers. For example, Saint-Yves certainly used and recommended silver in the earlier years of the eighteenth century. V. Graefe, in 1826, was using a solution of the nitrate, ten grains to the ounce. In 1830, Velpeau adopted silver in inflammations of the eye. Gouzzé, a Belgian surgeon, in 1839 warmly advocated a concentrated solution of the caustic for the treatment of a disease then known as the "Egyptian ophthalmia," commonly but erroneously supposed to have been introduced into Europe by the return of the French troops from Napoleon's Egyptian and other campaigns. Guthrie, of the Royal Westminster Ophthalmic Hospital, London, treated trachoma by an ointment which contained about eighty grains of the finely pulverised silver salt to an ounce of hog's fat. This preparation, commonly known as Guthrie's "Black Ointment," or more pedantically as the "Unguentum ophthalmicum magicum," was applied directly to the conjunctiva by means of a brush, and the application was repeated daily. Graphic accounts are upon record of the sufferings caused to patients by this somewhat heroic, although doubtless efficacious, agent. In 1842, Desmarres ("Mémoire sur une nouvelle méthode d'employer le nitrate d'argent dans quelques ophtalmies," Paris, 1852) described a new application of silver nitrate. He clearly distinguished between the astringent and the caustic effects of the remedy, which he employed as a solution containing 40 to 90 centigrammes in ten grammes of water, dropped into the eye every half-hour for forty-eight hours. William Mackenzie in his classical "Practical Treatise" (1854) describes the action of the silver in catarrhal ophthalmia in the following graphic words:—"I have sometimes alarmed other practitioners," wrote Mackenzie, "by proposing to drop upon the surface of an eye highly vascular, affected with a feeling as if broken pieces of glass were rolling under the eyelids, and evidently secreting puriform matter, a solution of lunar caustic; and I have been," he continues, "not a little pleased and amused at their surprise when, next day, they have found all the symptoms much abated by the use of this application." A treatment for so-called "strumous" inflammation of the conjunctiva and cornea that had a large vogue at about this time consisted in applying solid silver stick to the palpebral conjunctiva. It is a somewhat curious coincidence that an identical treatment has been recommended this year by Schiele (*Woch. f. Therapie u. Hygiene des Auges*, September 8th and 15th, 1904).

The employment of silver nitrate was extended by the encomiums of that great master of ophthalmology, Von Graefe, and popularised by the recommendations of Scarpa, Arlt, and others.

Nitrate of silver, then, reigned supreme in the treatment of superficial eye diseases until comparatively recently. That it possessed disadvantages was recognised even by its most strenuous advocates, but it was generally felt that these were more than outweighed by its potent escharotic, astringent, and

antiseptic properties. It was admitted on all sides that the remedy called for no little experience in its application; that much pain was often caused; that it might destroy tissue if used carelessly; that it did not penetrate deeply owing to insoluble compounds formed with albuminoids; and, finally, that its long-continued use was liable to produce an indelible staining of the tissues, as the conjunctiva and the cornea, with which it was brought into contact. William White Cooper perhaps summed up the position when he wrote:—"But the nitrate of silver is the most frequent agent of mischief; powerful for good if used with judgment, it is all-powerful for evil if misused" ("On Wounds and Injuries of the Eye," London, 1859, p. 290).

Of the caustic effects of silver nitrate I have personally witnessed several deplorable examples. In one case a nurse applied to the palpebral conjunctiva a concentrated solution of the salt, with the result that the conjunctiva became sloughy and ulceration of the cornea was set up. The patient made a slow recovery, but with scarred conjunctiva and defective sight, due to the corneal cicatrices. In another case a woman had had a rectus muscle advanced for the correction of a divergent squint. A fortnight or so after the operation, a small button of granulation tissue was found to be growing from the site of operation. It was determined to cauterise the little growth. Accordingly, a stick of silver nitrate, fixed in a goose-quill holder, was held under a stream of water for a moment for the purpose of freeing it from some impurity. It was then used to touch the excrescence. The front of the eye, including the cornea, at once became covered and hidden by a whitish film, which, under the influence of the bright sun shining into the room, turned black in a few moments, so that the eye presented a horrifying appearance. The explanation of the untoward circumstances was simple. Water had remained in the quill above the silver point, and when the eye was touched with the stick, the parts were immediately flooded with a highly concentrated solution of silver. The cauterisation was fortunately superficial, and the patient eventually made a good recovery. In a third case, the facts of which I communicated to the Ophthalmological Society in 1900, a lad, *æt.* 9, had been operated on for trachoma elsewhere by removal of the granulations by silver nitrate followed by irrigation of the eye with a solution of sodium chloride. When I saw the patient about a month later, I found extensive cicatrices of the conjunctiva and slight symblepharon, while in addition about two-thirds of one cornea was occupied by a greyish-yellow deposit, apparently of silver chloride. Vision was reduced to one-thirtieth of the normal. Lastly, I have notes of a case where a nurse rubbed the palpebral conjunctiva of a boy, *æt.* 11, with solid silver nitrate in mistake for some other application which had been prescribed. The results were serious, since one cornea became sloughy and eventually leucomatous, with sight equal only to the counting of fingers at half a metre from the face. Moreover, an adhesion formed between the inner part of the lower lid and the eyeball.

During recent years, a host of remedies, nearly all the output of the unceasing labours of the busy synthetic chemist, have been introduced as substitutes for silver nitrate. The list, already a long one, includes argyrol, protargol, largin, collargol, itrol, arginine, argentamine, and silver lactate. For most of these products it is claimed that, whilst as efficacious as the nitrate, they penetrate more deeply, possess higher bactericidal powers, do not stain the conjunctiva or the cornea, can be employed by inexperienced hands without risk, and, last but not least, that they cause little, if any, pain. Clinical investigation has confirmed some of these claims, and has at the same time negatived others. Certain of the agents named have already sunk into a deserved oblivion, but others appear calculated to replace silver nitrate in some, if not in all, of its applications at no very distant date.

For my own part, since I became thoroughly familiar with the action and uses of protargol, and more especially of argyrol, I have not employed silver nitrate in

the treatment of a single disease of the eye. Cases that once would have seemed to me to cry aloud for lunar caustic have yielded to the action of the newer remedies, so that what was once more or less of an experiment in my practice has been converted into a firmly established and very substantial fact.

In my subsequent remarks I shall consider briefly the advantages and disadvantages of the three silver substitutes of which I have had the most experience, namely, (I) Largin, (II) Protargol, and (III) Argyrol.

#### I.—LARGIN.

Largin, a synthetic compound, has not attracted so much attention from ophthalmic surgeons as, in my opinion, its intrinsic merits deserve. It contains 11 to 10 per cent. of silver combined with protalbin, and occurs in the form of a stone-coloured, granular powder soluble in water. It is a non-irritating bactericide possessing some astringent properties. I have employed largin as a 3 per cent. to 10 per cent. solution extensively in the treatment of superficial eye disorders more especially in the various forms of ophthalmia. Its application causes neither pain nor irritation in these strengths, neither is it followed by appreciable reaction. It has been claimed by Falta (*Centr. bl. f. prakt. Augen.*, February, 1899) that largin does not stain the conjunctiva after long-continued application, but my experience has furnished me with more than one instance where this complication was observed. Indeed, elsewhere (*Brit. Med. Journ.*, March 17th, 1900) I have published ten cases where argyrosis was produced by largin, and since then I have met with many more. Rightly or wrongly, I have formed the opinion that largin is more apt to stain the tissues than even silver nitrate itself.

In the gonococcal ophthalmia of newly-born children I have found that a 10 per cent. solution of largin is inferior to both silver nitrate and to protargol. The case is, however, altogether different as regards acute contagious ophthalmia, an affection common at certain seasons in England, and nearly always due to the tiny Koch-Weeks' bacillus. In twenty such cases, some of a severe character, a rapid cure followed the daily application to the conjunctiva of a 10 per cent. solution of largin. In acute trachoma, also, the same remedy yielded good results in subduing the obvious signs of inflammation, and in paving the way, as it were, for the use of more powerful means, escharotic or surgical. In blepharo-conjunctivitis, common in poorly-nourished and ill-cared-for children, and generally associated with pyococci (*s.p.* aureus and albus), a 3 per cent. solution gave good and speedy results when applied to the eyes three or four times a day. In suppurative affections of the lachrymal sac a similar solution, applied either as "drops" or by injection, succeeds admirably.

In brief, the application of largin is painless, but when prolonged beyond a few weeks, is apt to stain the conjunctiva of an indelible light-brownish hue. The more resistant cornea withstands the action of largin for longer than the conjunctiva, but eventually it also takes on the stain. Largin is an efficient substitute for silver nitrate in any of the conjunctival inflammations associated with the Koch-Weeks' bacillus, such as acute contagious ophthalmia and acute or subacute trachoma. Largin, in fact, is specific as regards that particular micro-organism, just as protargol is specific as regards the gonococcus. Largin also acts well in blepharconjunctivitis and in dacryocystitis. As is the case with all silver preparations, it is a matter of practical importance that largin should be brought thoroughly into contact with all parts of the diseased membrane.

#### II.—PROTARGOL.

Protargol can scarcely be mentioned without associating the product with the name of Dr. A. Darier, of Paris, to whom we owe the introduction into ophthalmology of this valuable synthetic product (*La Clin. Ophthal.*, January 10th, 1898). It is a combination of silver (8.35 per cent.) and protein, and is met with in the form of a yellowish powder, readily soluble in cold water.

My experiences with protargol have, upon the whole



been favourable as regards eczematous blepharitis (blepharitis ulcerosa), gonococcal ophthalmia, acute contagious ophthalmia, and suppurative affections of the lachrymal passages. Attention to the strength of the preparation I have found to be important. Thus, in cases of ophthalmia neonatorum, due to the gonococcus, 5 per cent. to 10 per cent. solutions, which I used at first, did not yield me any striking successes. They were, indeed, inferior to the 2 per cent. silver nitrate in common use. A 50 per cent. solution, to which I then resorted, gave results that it would be difficult or impossible to surpass. In acute contagious ophthalmia I employed a 10 per cent. to 20 per cent. solution with happy results, and in lachrymal affections a 3 per cent. to 5 per cent. solution. In many cases of blepharitis, cure was brought about by the thorough rubbing into the diseased part of an ointment containing 10 per cent. of protargol. But since I acquainted myself with Dr. Darier's soaping (*savonnage*) I seldom find it necessary to resort to the ointment. A 50 per cent. solution is used, and this is rubbed into the edges of the eyelids by means of a brush steeped in the liquid. A kind of *savonnage* of the parts is thus obtained, which is often capable of curing even rebellious cases of that unsightly disease.

To my mind, the disadvantages of protargol are two in number, and the recognition of these has prevented me from using the remedy as much as I formerly did. They are: (a) staining of the conjunctiva; and (b) pain and discomfort. The discoloration after prolonged use of protargol even exceeds that observed after the use of largin. After three months' employment once a day of a 10 per cent. solution I have seen the parts assume a dirty brownish hue as unpleasant to the patient as it was unsightly to the bystanders. Discomfort short of actual pain is a not uncommon complaint in my experience, but real pain, on the other hand, is distinctly rare. In some instances these drawbacks appear to be due to incorrect dispensing of the solution, to the keeping of stock solutions, or to the reducing effect of light. The water must be cold, and the powder must be dusted on the surface of the liquid, which is then allowed to stand until solution has taken place. On no account must hot water be employed. Small quantities should be made at a time, and the solution should be kept in non-actinic bottles.

### III.—ARGYROL.

We now come to a product, the latest and, in my opinion, the best of them all, which has popularised itself in a wonderful way since its introduction into practical ophthalmology less than three years ago (*Med. Record*, May 24th, 1902). It is known as argyrol, or silver vitellin. It contains no less than 30 per cent. of metallic silver combined with a proteid substance. Notwithstanding its high ratio of silver-content, I have never known it cause the least pain, irritation, or reaction. It is extremely soluble in water.

During the last eighteen months I have employed argyrol upon an extensive scale, chiefly in all kinds of conjunctivitis, in blepharitis, in phlyctenular affections of the cornea and conjunctiva, and in affections of the lachrymal passages. My experiments have been made with a 15 per cent. solution, and only in cases of gonococcal ophthalmia have I resorted to a 20 per cent. strength. The weaker liquid has been dropped into the eye three to eight times a day according to the kind and severity of the inflammation. The stronger liquid has been painted over the exposed conjunctiva once or twice in the twenty-four hours. An argyrol ointment, as will be explained later, has been used, chiefly in phlyctenular affections of the eye.

Almost the first thing that struck me about argyrol was the fact that many patients volunteered the statement that even after the initial application relief to symptoms was obtained. It thus appeared to act as a direct sedative to the inflamed mucous membrane. No single patient has ever complained of any pain attending its use. No caustic or escharotic action ever follows its use. To judge from its effect on cases of acute contagious ophthalmia, its powers of penetration must be of a very searching description. The sym-

ptoms of a sharp attack of acute conjunctivitis, due to the Koch-Weeks' bacillus, may be subdued in the course of two or three days, and that, be it remembered, without the least discomfort to the patient. I have further found argyrol capable of quickly healing those small peripheral ulcers of the cornea which are now and then associated with acute catarrhal ophthalmia in middle-aged and elderly people. As is well known, these small ulcers may become extremely painful, a symptom that speedily yields to argyrol. A 15 per cent. solution used as an injection in suppurative lachrymal affections has, in my hands, often dried up the muco-purulent secretion and materially assisted in restoring the tear passages to a healthy condition. In ophthalmia neonatorum, due to gonococcal infection, the 25 per cent. solution painted once or twice a day over the conjunctiva, exposed for that purpose by eversion of the lids and carefully dried from adherent discharge, with the frequent use by instillation of the 15 per cent. or of a weaker solution, will cure the case as quickly and certainly as any remedy with which I am acquainted. If ulcers of the cornea are present when the case falls under notice, argyrol is more than ever indicated, and should then be used twice a day. In such cases I believe I have seen benefit from letting the argyrol run freely over the ulcerated surface of the cornea, a thing that may be done with perfect safety.

Many cases of obstinate ulcerative blepharitis may be cured by rubbing the inflamed lids vigorously with a pledget of wool soaked in the 15 per cent. solution, and repeating the process, at first daily, and later at longer intervals. This, combined in the more severe cases with occasional cauterisation of the little ulcers lying at the roots of lashes with the acidum carbolicum liquifacuum of the "British Pharmacopœia," is the best treatment that I have ever adopted in long-standing and rebellious cases. It need scarcely be added that before the argyrol is used every trace of scab should be removed from the inflamed edges of the eyelids. An ointment containing 10 grains of argyrol to the ounce of vaseline acts well in many cases of eczematous (phlyctenular) conjunctivitis and keratitis, and if marked photophobia and blepharospasm be present, two to four grains of alkaloidal atropine may with advantage be added to the prescription. The ointment, simple or combined, should be applied two or three times a day. There are few cases even of the most intense blepharospasm that will not yield to this treatment, especially if at the same time the patient's forehead be painted daily with liniment of iodine until the skin becomes sore and slightly cracked. I need say nothing of constitutional remedies, which are called for in practically every case.

The only form of conjunctivitis in the treatment of which argyrol has disappointed me is in the chronic or subacute form due to the Morax-Axenfeld diplobacillus, the so-called "angular blepharitis," where the zinc salts, in rather strong solution, have seemed to me much superior.

It has been claimed that argyrol never stains the conjunctiva, no matter in what concentration or for how long it may be applied. If this be true, it at once gives argyrol a superiority over the other salts of silver, organic or inorganic. The claim, however, needs some slight modification, inasmuch as in one case I have seen argyrol produce slight argyrosis. The facts are as follows:—Miss E., æt. 54, suffering from a chronic and rather severe palpebral conjunctivitis, was ordered a 15 per cent. solution of argyrol for use four times a day on August 22nd, 1903. On October 2nd, the number of applications was increased to five a day. On January 13th, 1904—that is to say, after she had used the remedy for 144 days—a very faint staining of the palpebral conjunctiva was noted. This is the sole instance I have met with.

### CONCLUSION.

Silver nitrate, although invaluable in the hands of those who know how to use the remedy, is apt to become a somewhat dangerous weapon if employed without due experience, skill, and discrimination. The knowledge of this fact has led chemists to endeavour

to find an agent that shall possess the antiseptic powers of silver nitrate without its undesirable qualities. It has been recognised that the clinical value of a silver compound depends upon the amount of the contained silver, and that is modified, often in an undesirable direction, by the other chemical constituents of the salt (see *Ophthalmoscope*, March, 1904). Hence, the last few years have witnessed the production of many new silver compounds belonging to the organic class. The ideal agent, according to Fraenkel, must fulfil the several requirements of not coagulating albumen or of precipitating sodium chloride, of ready solubility in water, of not producing pain or of setting up irritation when applied to the eye. Largin, protargol, and argyrol fall more or less in line with these requirements. The staining propensities of largin and especially of protargol make me give the preference to argyrol as an agent for general employment. So far as my personal experience goes, it never does the least harm, while it is, without doubt, an efficient, speedy, and painless remedy in most superficial affections of the eye.

## THE PERSONAL ELEMENT IN THE ADMINISTRATION OF ANÆSTHETICS. (a)

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THE title of this paper may be a little ambiguous, so, at the outset, I must mention that I do not mean by "personal element" that of the anæsthetist, but entirely that of the patient.

No two persons are exactly alike, and so the anæsthetist finds that his patients do not correspond in every detail. It is in consideration of some of these personal points which I have met with in my work that I desire to occupy your attention for a brief space.

I am frequently asked by students: "How do you know when a patient has had enough?" I briefly recapitulate the different stages of anæsthesia with their signs, and these embryo practitioners probably go off quite satisfied in their own minds that they will be able to give anæsthetics as soon as they have gained the coveted degree or diploma. These students are not asked by their examining bodies to produce a certificate of having devoted a certain amount of time to this branch of their profession, so they do not consider it worth while to voluntarily attend a short course of lectures and demonstrations on such an important subject. A small percentage of students in a medical school will be found to be interested in the subject for its own sake, but the majority, knowing that there will be not even a single question on the subject, will become qualified to practise without having considered the rudiments of anæsthetics and their administration. Their qualifications to practise, however, entitle them to administer such potent drugs as anæsthetics, and the general public consider their freshly acquired degree or diploma a guarantee of their ability "to give chloroform."

Many practitioners remain content with a knowledge of the general signs of anæsthesia without a thought of any peculiarity, from disease or otherwise (the personal element), on the part of the patient. "He took the anæsthetic very well" and "he took it very badly" are common expres-

sions. The latter may be due to faulty administration or to the personal element on the part of the patient, in whom some condition, known or unknown, renders a perfectly smooth condition of anæsthesia more or less impossible, and it is only experience or alert thoughtfulness which can forestall or control difficulties as they arise.

Numbers of such cases are to be met with, and Hewitt has given us the benefit of some of his valuable observations in two lectures entitled "The Anæsthetisation of So-called Bad Subjects" (*Lancet*, January 10th, 1903). In these he points out the part played by such familiar conditions as nasal or other obstructions liable to cause respiratory embarrassment; a full set of powerful teeth set in a strong jaw; a very muscular man, and a man of the "John Bull" type, &c. A full and careful perusal of these lectures by such an authority will amply repay the reader.

*Alcoholism.*—This is perhaps the most familiar of examples of the patients' personal element so far as it affects the production and maintenance of anæsthesia. Alcoholics are admittedly bad subjects, and we approach them with a certain amount of dread when the administration of an anæsthetic is desired. It is not an absolute necessity that alcoholism is synonymous with difficulty. Occasionally it will be found an easy task to anæsthesise an alcoholic. I have given an anæsthetic the day after a "spree" without the slightest trouble. On the other hand, a dentist and I had quite a little scrimmage with a young fellow before anæsthesia resulted. He admitted having had five glasses of brandy during the day, and it was then only 3 o'clock.

I have come to consider that the ethyl chloride-ether sequence is the best for inducing anæsthesia in an alcoholic.

*Fear.*—This is a great source of worry and trouble to an anæsthetist, and it has been the cause of many so-called accidents. I have had many very nervous patients to deal with, whom it was difficult or impossible to reassure. I have heard them give directions regarding the care of their children and their affairs, fearing approaching death, even after being seated in a dentist's chair or placed upon the operating table. Such cases would be enough to scare a timid administrator, and cannot fail to increase the anxiety of an experienced anæsthetist. Should a fatality occur the anæsthetic or the anæsthetist would no doubt be accredited with the death, whereas fright has no doubt had more to do with it. That death from fright can occur has been proved. One case occurred in Edinburgh. The patient was placed on the table, and before the administration was commenced was found to be dead. Hewitt quotes a case of Kappeler's, and two cases of death from fear prior to the administration of an anæsthetic are the subject of a leading article in the *British Medical Journal*, February 21st, 1903. Had even the smallest quantity of anæsthetic been inhaled in these cases they would have been branded deaths due to the drug. There is no doubt that the element of fear is one to be dreaded by any administrator. May I mention that it is decidedly wrong for an operator, in attempting to reassure the patient and friends, to make the dogmatic statement that there is absolutely no danger, for it would put the anæsthetist in a most unfortunate position should a fatality result?

(a) Paper read at a meeting of the Belfast Division of the Ulster Branch of the British Medical Association.



**Shock**, either due to the condition requiring operation or occurring during operation, is a source of increased danger and requires the exercise of such care. I have met with it prior to operation in cases of severe accident with or without the loss of blood, in cases of rupture of the bowel or stomach, &c., and during operations in abdominal surgery, where a profound impression has been made on the solar plexus and acting reflexly through the vagus. Once did I meet it in enucleation of the eyeball following pan-ophthalmitis. Stretching of the sphincter and cutting the cord in excision of the testis are liable to cause shock. In his Address on Surgery at the recent Oxford meeting, Sir Wm. MacEwen dealt at length with the cardiac and respiratory reflexes which may be obtained through the pudic nerves, and I am glad to see that he does not now blame the anaesthetist as he once did. In such conditions, where shock is either present or its occurrence feared, a preliminary injection of strychnine ( $\frac{1}{16}$  gr. for an adult) and either ether or a mixture containing it is, in my experience, the best method of procedure.

**Glycosuria** is a condition in which one fears ill after-effects. I have had a few such cases, and I always give ether if at all possible, and my reason is, that chloroform has been known to be followed by sugar in urine which had hitherto been free. I have had invariable success with ether and no ill after-effects. Coma has followed the administration of an anaesthetic in diabetes. I have not seen it. One case that I have notes of had slight glycosuria when admitted to hospital. This had disappeared by dieting before operation for a radical cure of hernia. I gave ether for an hour, and no sugar appeared as a result.

**Albuminuria** is another condition which induces me to give ether unless otherwise contra-indicated. Thompson, Buxton, and Levy have demonstrated that there is "no specific ether effect" upon the kidney. Chloroform, on the other hand, has occasionally caused albuminuria.

**Pregnancy**.—Apart from anaesthetics given in obstetric practice I have been called on frequently for surgical or dental cases during pregnancy, and my experience goes to prove that it is not a contra-indication to the use of an anaesthetic. Perhaps my best example was a case of nephrectomy taking over an hour during the fourth month. The patient returned to hospital and was delivered at full term.

**Empyema** cases are particularly anxious ones, especially as the majority are operated upon by turning the patient upon his sound side for the benefit of the surgeon.

**Coma**.—Only once have I had to give a comatose patient (a girl,  $\text{aet. } 17$ ) an anaesthetic (trephining for cerebral abscess). There was no conjunctival and slight corneal reflex when the patient was placed upon the table. I gave A.C.E., and very little of that was necessary.

**Valvular Disease** is not a contra-indication to the use of an anaesthetic if compensation is perfect. Care is very necessary that no undue strain is put upon the heart in any way. I have had two cases with double aortic murmur and used ether. Mitral disease is much more common. Irregularity is a greater cause for anxiety. In one case in which I gave ether for the amputation of a foot in a young man, the heart became irregular during the administration and remained so the following day. It was, no doubt, functional.

Certain conditions arise during the administration which must influence more or less the administrator.

**Vomiting** is a very familiar cause of trouble on the part of the patient, especially to the inexperienced, the reason being that he is not able to keep up such an even degree of anaesthesia as one with more practice. Some patients do not suffer from nausea or vomiting to even the slightest degree, whilst others are greatly upset by it. When a patient vomits during an operation it is a sign that he is not getting enough—in other words he has returned to the second stage of anaesthesia in which the vomiting centre is no longer paralysed. It is the more frequent inability of the inexperienced to maintain evenly the third stage that accounts for his greater trouble with this troublesome complication. The older teaching that alteration in the size of the pupil is an index of the onset of vomiting is fallacious. I have several times seen the pupil remain contracted during vomiting. Swallowing movements and pallor are frequent precursors. Vomiting is mostly due to the irritation of the vomiting centre by the anaesthetic, and its irritability varies greatly in different individuals. The swallowing of saliva in which some of the anaesthetic is dissolved no doubt is a cause of vomiting by its action upon the mucous lining of the stomach. I have had frequent opportunity of proving the fact that a patient who suffers from prolonged and severe vomiting after chloroform may suffer little, if at all, after ether given for a further operation.

Vomiting after ether, though more frequent than after chloroform, is usually not so severe, but I have notes of one remarkable case in which it persisted from Wednesday morning till Saturday evening after ether given for an appendicectomy.

**Faecal vomiting**, or, as I think it should be more properly called, faecal regurgitation, as a symptom of the condition requiring operation should be accepted as a warning for great care. The fluid regurgitates from a stomach more or less distended, the only means of exit (for example in intestinal obstruction) being by the mouth, and the epiglottis is not closed as in the act of true vomiting. Respiration proceeds normally and the inspiratory act draws the faecal fluid into the trachea. I have once seen death result in this way, and I determined that in all such cases I would wash out the stomach prior to giving an anaesthetic. I have more fully reported this and a successful case elsewhere (*MEDICAL PRESS AND CIRCULAR*, January 27th, 1904), and since I have added half a dozen more cases to my list in which I have drawn off the faecal fluid by a syphon tube, and then washed out the stomach. In this way I considerably reduced the danger and difficulty in what are acknowledged to be bad subjects for anaesthetics.

**Spasm**.—This may be general, as is more particularly seen in very muscular individuals, or it may be local—*e.g.*, of the jaw or of the glottis. Heavy smokers are liable to spasm of the jaw, and Hewitt suggests that it may be due to hypertrophy of the muscles caused by constant puffing or pulling of the pipe, &c. Spasm of the glottis may be the effect of an unusual delicacy of the mucous lining, or it may be that too concentrated a vapour is being inhaled. In either case a more dilute vapour must be used. Impure drugs which may be the source of trouble must of necessity be avoided. Spasm of the jaw is much more common than that

of the glottis and may be very severe. The worst case I have had was in a tetanus case with some trismus, to whom I administered ethyl chloride for the amputation of a toe. Forcible use of the gag sufficed to remedy the condition.

*Cyanosis* may be the result of spasm of the jaw or larynx, or it may occur independently of either. Its presence must always make an anæsthetist very watchful, for whatever the cause there is great risk of unhappy cardiac effects. Forcible opening of the mouth and traction upon the tongue may relieve the cyanosis, and sometimes the gag, with or without pushing forward the angle of the jaw, may suffice. In desperate cases tracheotomy may be the only remedy. I have not had to resort to the use of the tubes which I always carry in my bag. I recently had a case in which deep cyanosis resulted when the patient was placed in the Trendelenberg position. Both gag and tongue forceps failed to relieve it in the slightest degree, and it was only when the flat posture was resorted to that it passed off. Another bad case that I have notes of was that of a gentleman who was to have hæmorrhoids removed. Chloroform caused deep cyanosis, whilst ether added to the trouble by causing such a great amount of coughing as to interfere with the operator who, learning the state of affairs, worked against time whilst I proceeded cautiously for a very uncomfortable twenty minutes. This patient smoked cigarettes to such an extent that he had furnished himself with a pound box of them for consumption during his stay in the private hospital. I have notes of two cases (twin girls, æt. 12) who both coughed severely and became cyanotic whilst getting chloroform prior to the removal of adenoids. Was its occurrence in both merely a coincidence or was it a natural tendency or due to the adenoids? I am not able to say which.

Several of my cases have demonstrated the fact that cyanosis may result from the presence of food in the stomach. In such cases it passed off when the stomach emptied itself by vomiting.

I have several times noticed the great tendency to cyanosis that there is in patients in the Trendelenberg position, who retch unless very deeply anæsthetised. The profound anæsthesia necessary to avoid annoyance to the surgeon, together with the effect of gravity, may be a source of great anxiety to the anæsthetist.

Milder respiratory effects than the foregoing are more frequent, e.g. :—

*Cough and Holding the Breath*, both of which are more common with ether or a mixture containing ether. Cough is generally the result of the direct effect of the anæsthetic on the respiratory mucous membrane, and in patients who are very irritable it may occur during deep anæsthesia. Should ether be the anæsthetic used it may be necessary to change to chloroform, and if it occurs with the latter the administrator will require to exercise his best endeavours to keep the patient anæsthetised with as dilute a vapour as possible. I have notes of one case in which there was frequent cough under chloroform, which was greatly diminished by painting the nasal cavities with a solution of cocaine. Cough may be due to excessive bronchial secretion. Even under chloroform I have seen such profuse secretion that cyanosis and cough both occurred, and it was necessary to encourage the coughing at intervals. Such cases fortunately are rare.

*Holding the Breath* may be due to too concentrated

a vapour, but, apart from this, is common in very nervous patients. When it occurs it is well, especially if chloroform is being given, to allow a free breath of air, as great risk is incurred by the inhalation of chloroform-laden vapour with the very deep breath which naturally follows.

*Excessive Buccal Secretion* requires removal either by occasional sponging or by a simple device suggested by Blumfeld (a) in his little book—viz. by the corner of a towel tucked into the dependent cheek, which has a syphonage action. I have found this hint very useful.

*Hiccough* is occasional. I have seen it a few times, but never very severe.

*Sneezing*.—This occurred several times in a young fellow during the inhalation of chloroform for enucleation of the eyeball for syphilitic iritis.

*Epilepsy*.—A history of this tends to increase our anxiety lest a fit should be induced.

I have had four or five cases, but in none did any trouble occur—one of the cases had had a fit in the external whilst being examined a few days previously. I have, however, notes of one case, without an epileptic history, which resembled what is described as an epileptiform seizure.

*Dilated Pupils* persisting after abolition of the corneal reflex puts an anæsthetist upon his mettle. This symptom may (but not invariably) be found under the following conditions :—

1. Digestive disturbance.
2. Shock, either before or during operation.
3. With profuse hæmorrhage.
4. After struggling.
5. In presence of the following three conditions—*anæmia, emaciation and pyrexia.*
6. After the general or local use of atropine or belladonna.
7. In those who have been very frightened.
8. With cyanosis.

I could quote many cases I have come across, but time does not permit. The greatest care is necessary in such cases lest, in trying to obtain contraction of the pupils, the anæsthetic is pushed too far.

*Unequal Pupils*.—I have frequently been able to demonstrate to students and others the presence of this condition. One pupil may be well contracted, whilst the other may be more or less dilated. This always increases my anxiety, for when present after abolition of the corneal reflex one cannot help feeling that the dilatation of one pupil may be a sign of danger. I should be glad to learn the significance of this phenomenon. I have thought that it may be due to some difference of refraction, but can offer no proof of this theory. Whilst writing this paper I had an exceedingly good example of it in the Royal Victoria Hospital. Dr. MacIlwaine and Dr. Nelson very kindly examined the eyes for me, but found such a very minute difference in the refraction of the two eyes that it hardly supports my theory.

I do not profess to have dealt with every condition on the part of the patient which must weigh with us in the administration of an anæsthetic, nor to have gone into detail in those on which I have touched; much more time would be necessary than is available at this meeting. I trust, however, that what I have said is sufficient to show that the proper performance of this branch of our profession is not such a sinecure as too many seem to suppose.

(a) "Anæsthetics." By Dr. Blumfeld. Medical Monograph Series. Baillière, Tindall and Cox, 1904.

### Clinical Records.

#### FALLOPIAN TUBES, LIGATURED TWICE AT PREVIOUS OPERATIONS, AND REMOVED IN THE CASE OF A THIRD CÆSAREAN SECTION. (a)

By J. W. TAYLOR, M.D., F.R.C.S.,

President of the British Gynæcological Society; Professor of Gynæcology in the University of Birmingham.

THE history of these specimens is as follows:—M.S., a strumous dwarf, æt. 25, with both curvature of spine and contracted pelvis, was married in July, 1900. She immediately became pregnant, and was sent to me for operation by Dr. Darroll, of Leintwardine, in February, 1901.

Labour commenced on the morning of March 20th, when I operated by Cæsarean section, removing a healthy female child which is still living. After suturing the uterine wound, I tied each Fallopian tube by a single ligature of silk as some bar to further pregnancy. The mother and child both did well, and left the hospital on April 17th, but remained at our Convalescent Home for some time longer. The following year (1902) the patient developed tuberculous disease of the right knee-joint, and her leg was amputated above the knee at Shrewsbury Infirmary on September 22nd, 1902. In 1903 she again became pregnant, and was sent up to me once more by Dr. Darroll towards the end of August. I did a second Cæsarean section on September 14th, 1903, removing again a living female child, which, however, was very feeble, and only lived about half an hour. After the suturing of the uterine incision was completed, I carefully examined the Fallopian tubes, and found considerable atrophy at each site of ligature. The atrophy was most marked on the right side, where the tube seemed narrowed to a point. The silk had been absorbed. I placed two fresh ligatures of silk on each Fallopian tube (four ligatures in all, but without any cutting or removal), and closed the abdominal wound. The patient did well after the operation so far as the section was concerned, but during the whole of the time of her stay in hospital she was troubled with chronic strumous conjunctivitis and ulceration of the cornea, an affection from which she had been suffering for nearly two years, in spite of the free administration of cod-liver oil. She went to the Convalescent Home on October 8th, 1903.

Early in this year I heard from Dr. Darroll that from the date of her return home she had never menstruated, and was evidently again pregnant. She came up in July last, and I found that this was indeed the case. On this occasion I determined to remove the uterine appendages, but was anxious not to hurry the performance of the operation so as to obtain a living child, if possible.

On August 4th I went for a holiday, and two days later, the patient beginning to be in labour, my colleague, Mr. Christopher Martin, kindly operated for me, removing a living child, which, like the preceding one, only lived about three-quarters of an hour.

Mr. Martin, before closing the abdomen, removed the whole of each tube, and a small portion of each corresponding cornu of the uterus. He also removed one ovary. The patient made a good recovery, and left the hospital soon after my return on September 7th.

On looking at the tubes removed, it may be seen that one tube is as completely divided by the double ligature as if a piece had been cut out of it, while in the other the whole of the muscular coat appears to be gone, but (in all probability) the mucous channel is still pervious.

In addition to the direct interest of these specimens as contributing to the general sum of knowledge regarding Cæsarean section, and the utility or non-utility of ligature of the tubes as a bar to future pregnancy, I must confess that they have a very

considerable interest to me as bearing on the question of the causation of tubal pregnancy.

It would, I suppose, be difficult to find two Fallopian tubes in which an ovum would be theoretically more likely to be stopped on its journey to the uterus, yet the pregnancy on each occasion after ligature was uterine and not tubal.

It seems to suggest that the cilia of the epithelial coat, even within the lumen of the tube, have more to do with the progress of the ovum than any peristaltic muscular contraction.

#### A LARGE ABSCESS OF THE OVARY.

THIS specimen is, I believe, a rather rare one, it being unusual to find so large an abdominal tumour due to ovarian abscess. The history is interesting:—The patient, Mrs. C. C., had been married five years, but had never been pregnant, when in August of this year she developed a rising temperature with obscure abdominal pains, and, rather naturally, was supposed to be suffering from typhoid fever.

She was seen on August 21st by another consultant, who diagnosed suppuration, and opened an abscess by the vagina on the 23rd, over a pint of pus and blood being evacuated.

This undoubtedly gave her very great relief, and she was able to get up and go out of doors a little later; but since this date an increasing enlargement was noticed in the lower part of the abdomen, the catamenia having ceased from the date of her illness.

When she was sent to me by Dr. Kingsland, about the middle of November, I found a remarkably prominent cystic swelling reaching to the umbilicus, and looking like a five months' pregnancy or a very distended bladder.

On examination, however, I found it was due to neither of these conditions, but to a tumour of the left ovary or left broad ligament pushing the uterus to the right. The lower pole of the cyst came down to the level of the vaginal cervix on the left side, the side of the uterus being apparently fixed to the wall of the cyst, and a diagnosis was made of adherent ovarian tumour or broad ligament cyst. The patient's temperature was never quite normal, but usually slightly raised; on the evening of admission into hospital it was 101° F. Under anaesthesia, on November 19th, I came to the conclusion that the tumour must be intra-peritoneal, and operated by abdominal section, removing a large single abscess of the left ovary, with dense adhesions to the pouch of Douglas at the site of the first tapping, or incision. As there was necessarily some fouling of the pelvis in the separation of these adhesions, I finished the operation by posterior vaginal celiotomy and gauze drainage. The pus removed was examined by my assistant, Dr. Smallwood Savage, and showed a pure growth of bacillus coli, but at no time during the operation was there any visible adhesion or channel of communication found between the ovary and the rectum. The patient made a good recovery, and went to the Convalescent Home two days ago.

### Transactions of Societies.

#### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, DECEMBER 8TH, 1904.

PROFESSOR JOHN W. TAYLOR, M.D., F.R.C.S.,  
President, in the Chair.

#### SPECIMENS.

##### CARCINOMA OF THE FALLOPIAN TUBE.

DR. MACNAUGHTON-JONES said that he exhibited this specimen solely for its pathological interest. For some years he had lost sight of the case from which the tumour was removed, and it was only recently that he had discovered the latter among others in his collection. When he had sent it for examination and report to Dr. Cuthbert Lockyer, it proved to be one of exceptional interest. The report was as follows:—"The tumour is oval in shape,

(a) Read and specimen shown at the British Gynæcological Society, December 8th, 1904.

and measures 10 inches in its greatest and 8 inches in its shortest circumference. It has a lobulated surface; some of the lobes are smooth, the growth being enclosed in a highly-stretched fibrous-looking shiny capsule. Other lobes are rough and papilliform, consisting of growth which has burst through the containing capsule. The smooth thin capsule has been peeled off the greater part of one portion of the growth, revealing a rough surface studded with nodules the size of a pin's head. A further portion of the tumour has been cut through its greatest diameter, the cut surface has a pale yellow colour, and consists of soft friable granular-looking material. At one point there was a small projection which admitted a fine bristle. This on transverse section proved to be the cut end of the Fallopian tube. On following this up it was found to lead through the capsule into the cavity containing the new growth. Sections have been prepared at various levels to show that the capsule of the growth is continuous with the wall of the undilated tube. These sections prove that the smooth capsule enclosing the tumour consists of fibro-muscular tissue continuous with that forming the wall of the unexpanded tube. The tumour is, in fact, of tubal origin."

Dr. Macnaughton-Jones remarked that unfortunately the clinical history of the case had been lost sight of, and he could not say what the ultimate issue was. In Mr. Alban Doran's recent paper in the *Journal of Obstetrics and Gynaecology*, October, 1904, there was a table of over fifty complete cases of primary cancer of the Fallopian tubes. Graefe, of Halle, had in 1902 found fifty-two recorded cases.

Mr. BOWREMAN JESSETT said that he had never met with a case of primary columnar-celled carcinoma of the Fallopian tube, and suggested that the specimen might possibly be a secondary growth of carcinoma of the bowel.

Dr. F. A. PURCELL also spoke of the extreme rarity of primary carcinoma of the tube, and suggested that there might have been primary growth in the uterus.

Dr. C. F. H. ROUTH asked what was the age of the patient.

Dr. MACNAUGHTON-JONES, in reply, said that the capsule of the tumour was a direct extension of the Fallopian tube; the analysis of Mr. Doran's cases showed that the uterus was involved in only six out of 53 instances.

The PRESIDENT showed "Fallopian Tubes Ligatured Twice at Previous Operations, and removed in the course of a Third Cæsarean Section"; also a specimen of a "Large Abscess of the Ovary." Notes of these cases will be found under the heading of "Clinical Records," page 657.

The PRESIDENT also exhibited three cases of CANCER OF THE BODY OF THE UTERUS, reading notes as follows:—The first, a simple case of cancer of the body, occurring in a married woman of 56 years of age, four years after the menopause, attended by the classical symptoms of watery, foul-smelling and bloody discharges for three months before operation. The uterus was removed by vaginal hysterectomy on October 31st, and on being laid open disclosed a fairly typical and very pretty specimen of the disease. The patient made a good recovery.

The second case appeared, clinically, to be one of ovarian tumour, complicated by a small uterine polypus or fibroid. The patient was single, æt. 43, never regular, the last normal period having taken place some three years previously; since then she stated that she had suffered from a daily coloured discharge, never profuse, and never amounting to more than a "show." On examination, she was found to have a large abdominal tumour reaching well above the umbilicus. The uterus was pushed backwards by the tumour; the cervix was open, and a small growth, like a polypus, which did not break down or bleed on examination, was just to be felt by the tip of the examining finger. I operated on November 17th, and on first attending to the condition of the uterus under anæsthesia

found that the growth presenting at the cervix was soft, brain-like, and almost certainly malignant. I therefore proceeded to remove the whole of the uterus as well as the ovarian tumour and the uterine appendages of the opposite side, hoping in this way to obtain freedom—or a longer freedom—from recurrence. The patient has done well, and is now convalescent. The uterine growth has been examined by Professor Leith, who reports upon it as malignant. The ovarian tumour is still under examination, but presents the rough general characters of malignancy.

The third case was originally one of myoma of the uterus, attended for several years by menorrhagia. The patient, a midwifery nurse, single, æt. 52, appeared to have passed through the menopause 18 months ago, and the hæmorrhage ceased. For six months an irregular foul-smelling discharge returned, and, in September and October last, she suffered from severe hæmorrhage with "floodings." The patient was virginal, and the vaginal cervix was free from any tangible ulceration. The tumour filled the pelvis, and therefore no estimate could be made of the fixation. The abdominal characters of the tumour were those of a fibroid. The diagnosis was made of cancer of the uterus or a "sloughing" fibroid, and I operated on December 1st, doing a pnhysterectomy by the combined method. There was pyometra and right pyosalpinx, and the extraction of the tumour was by no means an easy one. During its removal the uterus tore at the junction of the body with the cervix, and the latter, which was removed separately, was unfortunately not preserved. The pathological examination appears to show that a malignant adenoma is invading a myomatous uterus, but the case is too recent to obtain a full report. The patient (to-day) is doing well.

Dr. HEYWOOD SMITH said that ligature allowed a certain amount of patency in the lumen of the tube; more radical measures were required to ensure sterility.

Dr. J. A. MANSELL MOULLIN concurred as to the inadequacy of ligature; the easiest and best course to adopt is to remove the whole of the tube at the primary operation.

Dr. J. H. DAUBER remarked that cases had been recorded in which both ovaries had been removed and yet the patient had become pregnant.

Dr. J. FURNEAUX-JORDAN said that Cæsarean section was now attended with such good results that he did not see the necessity of sterilising a young woman merely because she could not have a child born through the pelvis.

Dr. MACNAUGHTON-JONES remarked that in some of these cases the method introduced by Pincus had been successfully employed to seal up the uterine canal by atmocausis. In regard to the specimen of carcinoma of the fundus, it was precisely similar to a case brought forward by him before the Society, and from the appearance of the uterus it did not seem that the cervix uteri was involved. In his case it was proved microscopically not to be so. It would be well that the specimen were examined to settle this point.

The PRESIDENT, in reply, said that though they now knew that ligaturing the Fallopian tube was a very poor bar to future conception, his critics must remember that in 1900, which was the date of his case, their knowledge was by no means so complete. However tightly a ligature was tied, the serous membrane and muscular tissue might offer such resistance that, in spite of the ligature, a minute aperture might be left through which the ovum could pass. The surest method of ensuring sterility was, he thought, that adopted by his colleague, Mr. Martin: to remove not merely the tube, but also the corresponding cornu of the uterus by a wedge-shaped or triangular incision, and to bring the edges of the wound together, so as to close the channel effectually by some depth of muscular tissue. For closing the wound in the uterus, he always used sterilised silk, and had not employed gut for that purpose for many years. The large ovarian tumour removed with the uterus, diagnosed

to be cancerous after curettage, had all the microscopic characters of a carcinomatous tumour, and if proved to be one, must have existed for several months before anything was known to be wrong with the uterus.

Dr. WILLIAM ALEXANDER read a paper on

ADENOMA OF THE ENDOMETRIUM,

illustrated by microscopical sections, photographs, and lantern slides, which will be found under the heading of "Original Communications," on page 649.

Dr. F. A. PURCELL noted that in some of the cases the ovaries had not been removed with the uterus. It was only of recent years that due consideration was being given to a conservation of the ovaries on account of the value of their internal secretion. He thought that the ovaries, if apparently normal, should never be removed.

Dr. MACNAUGHTON-JONES said that he had brought cases precisely similar to those described by Dr. Alexander before the Society, in which the adenomatous changes mentioned by him had been present. In the new edition of his book, the macroscopical and microscopical appearances mentioned by him were fully illustrated, and at the last meeting he had shown a uterus in which the cavity was filled with the same gelatinous and mucoid substances as described by Dr. Alexander. It was due to the breaking down of the epithelial *débris*, and the hæmorrhage was caused by necrosis of the vessels, the result of pressure due to the glandular change. The subject was a very important one, as the recurrence of the hæmorrhages brought about a most serious condition, and at times a profound anæmia. Curettage was useless as a means of treatment, and the proper course to pursue in these cases, when the diagnosis was made, was to remove the uterus. In certain of these cases the ovaries were also diseased, and if so, they should be removed with the uterus.

Mr. BOWREMAN JESSETT, alluding to the gelatinous condition of the uterine mucous membrane, said he had not the slightest doubt that it was a pre-cancerous condition, and that certainly in the first case, if left alone, it would have developed into malignant disease of the fundus of the uterus; he had seen several cases of the sort, but the diagnosis of such pre-cancerous conditions was still obscure. It was a question whether in a woman of forty years of age, suffering from persistent uterine hæmorrhage, one would be justified in removing the uterus, if microscopical examination of the scrapings by the curette did not show malignancy. He thought not in the majority of cases. But he was certain that he had seen cases pronounced to be non-malignant on such examination afterwards prove to be so. If these pre-cancerous conditions could be detected earlier, and the uterus removed in time, many a woman's life would be saved.

Dr. J. A. MANSELL MOULLIN said that though the curette in these cases was not an efficient cure, it was still of great value in diagnosis, as, when it did bring away malignant tissue, the removal of the uterus was clearly the only right course to adopt.

Mr. FURNEAUX-JORDAN stated that in the first five cases he had operated upon for this disease he had previously tried in vain to stop the hæmorrhage by the use of the curette, but in the last three cases he operated on had not done so, as he had come to the conclusion that it was not advisable. If profuse hæmorrhage, such as occurred in this disease, was allowed to continue, the patient would probably die before malignant disease had time to show itself. The condition was a most serious one, and required radical treatment.

Dr. ROUTH confessed that in the course of his practice, rather a long one, he had never had occasion to remove a non-cancerous uterus. He had not found scraping of the uterus of much use; much better results would follow the intra-uterine application of the strongest carbolic acid. In several cases of persistent bleeding, even with a bad odour, he had cauterised the uterus with a red-hot iron; this had

never caused any bad symptom, and the patients had got perfectly well. There was no justification for removing the uterus for hæmorrhage, unless it was certain that the case was one of malignant disease.

Dr. HEYWOOD SMITH thought that in case met with sufficiently early, intra-uterine measures should be tried. Chloride of zinc might destroy the hæmorrhagic condition, and give the uterus a chance to recover itself, nor did he see why the actual cautery should not be applied. Such an application might stop the hæmorrhage, but if not he would consider the advisability of removing the uterus.

The PRESIDENT, after cordially thanking Dr. Alexander for his paper, said that the question of glandular inflammation was certainly the one that at present was attracting most attention from gynæcologists, and the more it was studied the less possible it seemed to draw a definite line between that condition and cancer. There was much in what Dr. Routh had said regarding the treatment of the disease in its early stages. Mr. Lawson Tait employed the actual cautery extensively, and with good results, but it was questionable whether the condition of the patient after such treatment was better than after the removal of the uterus. He asked Dr. Alexander whether in adenoma of the endometrium he included all cases of metrorrhagia. He had himself met with cases in which microscopical examination disclosed a growth in the tubes after the removal of the uterus; in others fibroid thickening was all that appeared. The diagnosis was a matter of great difficulty, especially when one had to rely entirely on the symptoms of the patient and the hæmorrhage; he had known instances in which bleeding had been profuse and almost continuous for two or three years, in spite of repeated curettings, and without any assignable cause had diminished, and at the menopause ceased, and some years afterwards the patient had continued quite well.

Dr. ALEXANDER, in reply, said that he always left the ovaries behind, as he believed this made the convalescence more satisfactory. He did not think that the disease was malignant; at all events, in his experience it seldom became malignant. His first patient after eighteen years did not seem to have any more of the growth than she had at the beginning of that time. In another case the bleeding has been going on for twenty years; the patient is still alive waiting for the menopause, and probably not any worse now than she was many years ago. Hysterectomy should only be performed in these cases when all other means have been fairly tried and have failed. When this is the case, the treatment, nowadays, of removing a uterus that had become useless and only a source of weakness to the patient can hardly be called heroic. In these cases the operation is a very simple and safe one for a very grave disease. He always removed the uterus in these cases *per vaginam*, and did not think there was any reason why it should ever be removed through the abdomen. He thanked the President and Fellows for their very kind remarks on his paper.

ECTOPIC GESTATION,

Dr. R. T. SMITH showed a specimen and read the following notes:—The patient was a Polish Jewess, æt. 30, married two years, with a child one year old, and the facts elicited were simply that four weeks ago, after two months' amenorrhœa, she was seized with sudden pain in her left side, and from that time had had a sanguineous discharge with clots. Examination revealed a soft swelling in the left side of Douglas's pouch, an old retro-uterine hæmatoma. At the operation, the tumour forming the adventitious sac, so well shown in the specimen, was surrounded by a considerable amount of blood, the escape of which had probably caused the pain. The anterior wall of the tube was extremely thin, and evidently on the point of a second rupture. The patient made an uninterrupted recovery. The interest of the specimen lay not so much in any special pathological feature as in its

structural completeness; the tumour was entirely tubal, the foetus with the head towards the uterus filling the whole tube, and also in the fact that the diagnosis depended almost entirely on the physical examination, the patient knowing so little English as practically to be unable to give any account of her illness.

DR. BEDFORD FENWICK showed a specimen of UTERINE FIBROID WITH UNUSUAL DEGENERATION.

The patient was *æt.* 31. She had been married thirteen months, and was confined on August 4th, 1904, at full time. The periods began at fourteen, had always been regular, lasting six or seven days, always profuse, and with slight pain. Since the labour, she had had increasing losses, and for some time past an increasing amount of most offensive discharge. She had been rapidly losing flesh, colour, and strength, and, in fact, presented the appearance and ordinary symptoms of malignant disease of the uterus. The cervix, however, was perfectly healthy, the uterus was enlarged, the anterior wall being hard and nodular, and the right ovary was large and tense. The sound passed easily  $3\frac{1}{2}$  inches forwards, and the uterine canal was quite smooth. Dr. Fenwick therefore diagnosed the case as one of degenerating fibroid and performed hysterectomy by abdominal section in the ordinary manner. The patient made an uneventful recovery, and rapidly gained flesh and strength, and her colour became normal.

The specimen showed that the anterior wall of the uterus contained two fibroids of about equal size, measuring  $3\frac{1}{2}$  inches across, and 2 inches from above downwards. Each fibroid was enclosed in a separate capsule, the upper one being uniformly thick all round. At the lower part of the lower fibroid necrotic degeneration has commenced, and the pus and debris were escaping from the small cavity through a narrow opening into the uterine canal, just above the internal os. The case was interesting not only because the specimen was so unusual, but because the symptoms so closely simulated those of malignant disease of the uterine body. It was also noticeable that the right ovarian artery which was obstructed by the fibroid outgrowths at the fundus was greatly thickened, its muscular coat being much hypertrophied, and the right ovary was converted into a large blood cyst, containing eight ounces of black blood, the tube also being swollen and thickened. The left ovarian artery was quite normal in calibre, and the left ovary and tube were perfectly healthy, and Dr. Fenwick emphasised the fact that where the ovarian artery entered the fundus on the left side the area was free from any fibroid outgrowth.

After some remarks from Dr. MACNAUGHTON-JONES, the specimen was referred for a pathological report, on the motion of Dr. Purcell, seconded by Dr. R. T. Smith.

The PRESIDENT said that their Editor had left on the table a copy of Dr. Macnaughton-Jones' "Diseases of Women," and particularly wished to draw attention to the beautiful illustrations in it of glandular endometritis bearing on Dr. Alexander's communication.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF MEDICINE.

MEETING HELD FRIDAY, DECEMBER 9TH, 1904.

DR. HAWTREY BENSON in the Chair.

#### LIVING EXHIBITS.

DR. COLEMAN exhibited a case of (a) Congenital Bulbar Paralysis.

DR. F. C. PURSER said he had to thank Dr. Coleman for having given him many opportunities of examining the case in hospital. Bulbar paralysis was certainly an uncommon disease, occurring in young children. The first time he saw the case he thought it could only be an anterior poliomyelitis, affecting the nuclei in the medulla oblongata, and so causing symptoms of paralysis, especially of the seventh, ninth, and twelfth nerves, but on thinking over the case he could not recall having seen or heard of such a condition, and so tried to think of any other explanation. He then

thought it might be due to a thrombosis or other vascular lesion, but thought it was improbable that the symptoms would be so localised, and also for that same reason such things as tumour, gumma, &c., were excluded. Another idea was that it was a pseudo-bulbar paralysis. There were cases of congenital or infantile bulbar paralysis recorded, but they differed in this respect: that there was a strong family history of it having occurred in more than one member of the same family, the parents also having been blood relations. Also the upper part of the face was as much affected as the lower. The observers attributed it to a hereditary tendency to early atrophy of the nerve nuclei, and a failure in the perfection of their development. Whether there were any pathological grounds for these theories or not, he did not know. The theories which he would submit himself were—first, an affection of the nerves themselves, rather than the nuclei from which the nerve fibres arose. In this connection he might mention a case of bulbar paralysis which had occurred suddenly in a young person after laryngismus stridulus. It might only have been a coincidence, but both were possibly caused by toxins. Secondly, a primitive myopathy may have affected the involved muscles. He certainly had never heard of such, but a hereditary disease had to begin somewhere.

DR. COLEMAN in reply, thanked Dr. Purser for his very interesting and instructive communication.

DR. COLEMAN also showed a case of (b) Pityriasis Rubra.

The CHAIRMAN said the case reminded him of a case of pityriasis rubra which had been an exact *fac simile* to that one, but there was no history of a preceding eczema. The chief point about the case had been that it got well under four or five weeks' treatment by arsenic.

DR. O'BRIEN said that the characteristic rash of pityriasis rubra was very abrupt, but in this case it had taken a considerable time to spread, which would contra-indicate pityriasis rubra.

DR. KIRKPATRICK took it that Dr. Coleman differentiated this case from an ordinary case of pityriasis rubra, as he looked on it as secondary, as it came on subsequent to psoriasis. He wished to know if Dr. Coleman thought the treatment of the psoriasis had anything to do with the causation of the pityriasis rubra, or exfoliative dermatitis. He thought it a pity to use the term pityriasis rubra, which had a definite connection with a form of disease, for conditions which were not similar to it, and he considered that the term exfoliative dermatitis described it better.

DR. COLEMAN, in replying, said that the only treatment used was calamine lotions and olive oil, or olive oil and lime water: simple emollients. He had not given arsenic on account of the acuteness of the case. There had been a distinct improvement during the last week. He had had a case of primary pityriasis rubra which had got well under similar treatment. As to diagnosis he thought that as the case had no other symptoms but universal redness and thin scales, they were sufficient to exclude any other skin disease but pityriasis rubra. It was not very essential where the disease began, as it might begin anywhere, and spread rapidly over the whole body. That being the case you would expect it to start from the psoriasis lesions, which it had done. He agreed with Dr. Kirkpatrick that exfoliative dermatitis would be a better term.

DR. T. P. C. KIRKPATRICK showed a well-marked case of Ichthyosis Simplex. The patient, a male, *æt.* 23, stated that the condition had been present as long as he could remember, but that none of his family ever had any similar condition. The patient has been recently infected with primary syphilis, and is now developing an extensive secondary pustular eruption on the trunk and limbs. The ichthyotic condition of his skin has not caused him any serious inconvenience.

DR. O'BRIEN said he had a patient, a man, *æt.* 26, with all his organs healthy, who had suffered from the condition for fourteen years. Three brothers had eczema, and two sisters. He thought these cases could be improved, but not cured.

DR. KIRKPATRICK, in replying, said it was of interest



to see whether the accompanying syphilis would have any effect on the disease, as in cases of ichthyosis associated with small-pox.

Dr. F. C. PURSER showed a Peculiar Deformity of the Spine, with nervous symptoms—a girl, æt. 8, who was born with spina bifida. Marked deformity of the spine remained, causing muscular wasting, anæsthesia, lost knee-jerk, and trophic sores on the left leg.

Dr. O'CARROLL reviewed three cases of Syringomyelia which he had formerly had under his care, and gave an account of the symptoms of a fourth, which had died recently. In this case the appearances were practically those of amyotrophic lateral sclerosis, with marked wasting in the muscles of the upper limbs, and some clawing of the hands. The remarkable feature of the case was the absolute absence of anæsthesia of any kind, though frequently searched for, coupled with tenderness to pressure of the second and third dorsal vertebræ and of the right second rib, which had led to a diagnosis of disease of those vertebræ inducing a compression myelitis. The cavity in the cord extended through the cervical and dorsal regions, was about 5 mm. in average diameter, and in some places was double.

Dr. COLEMAN said they had to thank Dr. O'Carroll for having thrown a lot of light on this disease, he having first described it in this country. He thought that the case would not have been absolutely diagnosed as syringomyelia from the symptoms, and he believed that more of these cases would be discovered if thorough *post-mortem* examinations were made, as Dr. O'Carroll was in the habit of doing. He himself had had a case of the disease under observation for the last ten years. It began when the patient was a boy of ten, and the muscular symptoms were then well marked, with the characteristic dissociation of sensations. The anæsthesia and sensory symptoms were present in the arms now exactly as they were ten years ago.

Dr. THOMPSON said the history of the case showed the difficulty of making a positive diagnosis, and the necessity for making thorough *post-mortem* examinations.

Dr. O'CARROLL, in replying, thanked those who had discussed his paper. He said he was under the impression that a fair number of those cases had spastic phenomena in the lower limbs, and the two other cases he had examined certainly had them. The case Dr. Coleman and he had shown was now in the Incurable Hospital, and doing well. He had well-marked spastic phenomena. In fact, he thought that syringomyelia might present a picture like a compression myelitis, except that it was uneven, and had the peculiar sensory phenomena and trophic disturbances, such as whitlows, perforating ulcers, talipes, &c.

#### SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, DECEMBER 16TH, 1904.

The President, Dr. ALFRED SMITH, in the Chair.

THE business of the Section was adjourned until the next stated meeting.

#### EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DECEMBER 7TH, 1904.

PROFESSOR JOHN CHIENE, C.B., President, in the Chair.

DRS. BURN MURDOCH and STUART McDONALD showed specimens of "Biliary Cirrhosis" in a young child.

Mr. SCOT SKIRVING showed (1) a simple form of coin-catcher; (2) old stereoscopic photographs of cases operated on by Professor Spence, Professor Syme, and others; (3) specimen of congenital syphilitic disease of the knee-joint.

Mr. MILES showed specimens of kidneys removed for calculous pyonephrosis, calculous hydronephrosis, and tuberculous disease.

Mr. CAUD showed Luy's urine separator with examples of urine obtained from each kidney.

Mr. A. G. MULLER read a short paper, entitled THE TOILET OF THE ANUS.

in which the risks of contamination of the fingers and of adjacent parts from an insufficiently cleansed anus were mentioned, and a simple method of purification described. Whatever means were adopted, the hands, especially the nails, were liable to infection, and required careful washing and disinfection after the anal toilet. Many local ailments were due to lack of cleanliness, particularly of the hands. Among these pruritus ani, abscess, piles, and fissure were mentioned. In many cases simple cleanliness did much to alleviate such conditions; in particular small rectal injections of cold water after washing were most useful both as palliatives for, and prophylactic against, hæmorrhoids.

In commenting on the paper, Dr. ALLAN JAMIESON spoke of the value of nightly injections of thin warm starch, to which a little liquor, bismuth, had been added in the treatment of pruritus ani.

Dr. AFFLECK spoke of the necessity of seeing that nurses were properly instructed in the importance of cleansing the parts in cases of typhoid in particular, and Dr. CHURCH, of the importance of purifying the nozzles of syringes used in giving enemata, &c., before introducing them into the bowel.

Professor D. J. CUNNINGHAM gave a lantern demonstration of some researches he had made on THE FORM OF THE STOMACH.

His slides were photographed from preparations in which the stomach and other viscera had been hardened *in situ* by formalin. The specimens shown confirmed, and to some extent supplemented, the recent observations of Professor His. It seems that the stomach normally lies more or less horizontally, not vertically, the greater curvature being somewhat anteriorly placed, close under the parietes. In formalin-hardened subjects, certain kinks and indentations are not infrequently found in the stomach. These are probably physiological, not the results of the hardening process. They to some extent coincide with Cannon's observations on the movements of the stomach of the cat when studied by X-rays. In some preparations the so-called hour-glass contraction of the stomach was shown, and the view was expressed that this was not a pathological lesion, but an appearance due to the fact that death had occurred during the occurrence of active peristaltic waves. The main point in Dr. Cunningham's communication was an attempt to show that the stomach was by no means an inert, passive sac or reservoir, but that it was an active, muscular organ which might assume manifold shapes, and that some of these, persisting after death, had been ascribed to a morbid process, whereas they were physiological.

A long discussion took place on Dr. Cunningham's demonstration, the general opinion being that there was not sufficient evidence that the changes he described actually occurred during life, and that it was possible that some of them might be agonal, or due to the action of formalin.

Mr. THOMSON remarked that in operating on the abdomen the stomach was usually relaxed, and that peristaltic waves were rarely seen.

Mr. STILES pointed to the frequency with which visible peristalsis occurred in congenital hypertrophy of the pylorus.

Dr. HARVEY LITTLEJOHN doubted whether if death took place while the stomach was acting the spasm would not at once relax. Except for the rare case of cadaveric spasm, death was followed by relaxation of muscular fibres. On the other hand, as rigor mortis set in muscular movements might take place, *e.g.*, the numerous intussusceptions so commonly met with in children.

DRS. RITCHIE, AFFLECK, and GREENFIELD discussed the recognition during life of the exact shape of the stomach by percussion, the latter emphasising the necessity for percussing down the mid-axillary line.

Dr. WATERSTON recounted some attempts he had made to secure X-ray photographs of the human stomach after large doses of bismuth had been swallowed.

Dr. RAINY spoke of the radiography of the organ in children.

Drs. Black, Caird, George Hunter, and Gulland also spoke.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, December 18th, 1904.

### FOREIGN BODIES IN THE NOSE.

FOREIGN bodies in the nasal fossæ are generally of small volume, which children introduce for amusement; they are also frequent in hysterical and insane persons. Buttons, pearls, beans, peas are those habitually employed. Foreign bodies coming from the pharynx can enter the nasal fossæ from behind. This accident has happened in cases of paralysis of the velum; but even where this is intact, the same may occur through the efforts of vomiting. It is thus that can be explained the presence of worms in the nose as has been sometimes observed. When these are of small volume they are often expelled by sneezing or of their own accord. When they sojourn, they are generally to be found at the anterior extremity of the turbinated bone or in the lower outlet. They can remain *in situ* a long while without producing any inconvenience other than an exaggerated secretion. Certain of these bodies, as beans or peas, may swell to a considerable extent, blocking up the whole aperture.

The symptoms provoked by the presence of a foreign body are at first an increase of the secretion of the pituitary membrane, but soon this latter becomes inflamed and the secretion is muco-purulent. This happens especially when the body is hard and embedded in the fossa. Ulceration of the mucous membrane is the result, which may end in its perforation. In such a case blood is mixed with the secretion. Sooner or later the secretion becomes foetid and the discharge is abundant.

The diagnosis of foreign bodies in the nasal fossæ is easy when of recent occurrence and before awkward attempts at extraction have been made. The stilette is the best instrument to detect the nature of the body, but it is well to apply to the mucous membrane a solution of cocaine before proceeding to expose; it facilitates the operation. If the instrument reveals a hard body the idea of a polypus can be excluded; it is a case of a foreign body, rhinolith, sequestrum, or osteome. The necrosis produced by the existence of a sequestrum causes extreme foetidity of the discharge, which does not exist in cases of foreign bodies.

As to treatment, in cases of adults or intelligent children, the blowing of the nose vigorously may be recommended and sometimes succeeds. The insufflator of Politzer may be tried in young children, but the nasal douche should not be employed as the jet of water may penetrate into the middle ear by the Eustachian canal.

If these simple means fail, what is to be done? asks Dr. Meiner. A bent stilette can be gently passed in and passed behind the obstruction, and extract it, or at least stir it so as to render it possible to seize it with forceps, or it can be pushed backwards into the pharynx, taking the precaution of passing the index finger of the left hand behind the posterior opening. In this way M. Menier, by means of a catheter, extracted a boot button from the nose of a child æt. 3, and which had been introduced into the nose two months previously.

Unfortunately all these operations provoke abundant hæmorrhage, which must be stopped before continuing the attempts at extraction. In my next letter I propose summarising the treatment of "Foreign Bodies in the Ear."

THE Council of the London and Counties Medical Protection Society, at its meeting on December 9th, resolved that on and after January 1st, 1905, an entrance fee of ten shillings be charged to all new members joining the Society.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 17th, 1904.

At the Ophthalmological Society, Hr. Greef reported on an examination he had made at the request of the Government on the sight of pupils in the schools. The inquiry, which had been carried out by himself and his assistant, had been an exhaustive one, and included enumeration and classification of all diseases met with, and measurements of light, height, and slope of desks and the distance between the desks and the seat, &c. He proposed that before the erection of any new schools the plans should be laid before a sanitary commission which should be empowered to order any alteration deemed necessary.

As regarded anomalies of refraction, he found that myopia was increasing in number and degree in all classes, and especially in the middle grades. Between the worst and the best lighted gymnasia there was no marked difference as regarded numbers, but as regarded degree, the worst lighted showed the highest degrees of the abnormality. A table prepared by Cohn showed that near eye work and not age played the chief part in its production.

He found myopia:—

In the Volksschulen	1.4 per cent.
In the Elementary Schools	6 per cent.
In the Higher Girl Schools	7 per cent.
In the Middle Schools	10 per cent.
In the Realschulen	19 per cent.
In the Gymnasium	26 per cent.

He explained short-sightedness as a process of stretching at the fundus oculi, and that the process was more common in early life. Schillnez looks upon it as a racial question. Germany had the most myopics, then came France, and then England. According to the speaker's views, however, it depended more on the habits of the race; as the sclerotic was stronger then the other body tissues were also strong. Sports and bodily exercise tended to a diminution of short-sightedness.

Hr. Hirsch, in the discussion that took place, said that the property of stretching was not limited to early life. Amongst 650 writers he found 245 myopics, of whom only 45 had been myopic during school life, so that they must have acquired their myopia by later near eye work.

Hr. v. Michel had examined the eyes in the Erlanger Gymnasium for myopia thirty-five years ago, and in the upper classes had found 88 per cent. of myopics.

At the Medical Society Hr. Grawitz related a case of LEUCÆMIA TREATED BY X-RAYS.

The patient, a man, æt. 54, came to him at the commencement of October in a very miserable condition. The proportion of red to white blood corpuscles was almost 1 : 1, the latter almost exclusively lymphoid cells. The liver and spleen were both swollen. After twenty-three Röntgen illuminations the general condition of the patient had not only distinctly improved, but examination of the blood showed only a slight deviation from the normal. Both liver and spleen were considerably reduced in size. Possibly the lymphoid cells were directly dissolved by the rays, but to determine that a quantitative determination of the urea was necessary. The case must not be looked upon as cured, but the influence of the X-rays was of therapeutic and biological interest.

Hr. Levy-Dorn showed a man who had had pseudo-leucæmic glandular tumours, and who had been treated by the X-rays. A distinct improvement had taken place in the general condition. Care should be taken when deep action was required not to bring the lamp too near the part to be acted on.

At the Free Society of Surgeons Hr. v. Schneider offered a contribution to the

### SURGERY OF THE PANCREAS.

A woman, æt. 43, had had repeated attacks of biliary colic, and again in August, 1902; in connection with this pneumonia developed, then she had pains in her left side,

and four weeks later fever, diarrhoea, pain and a tumour at the arch of the left rib; exploratory puncture gave pus. The speaker opened the abscess and came into a cavity that reached to the spine and contained great necrotic pieces which proved to be gangrenous pancreatic tissue.

After a time a fæcal fistula formed, which, however, closed spontaneously, and in the course of ten weeks recovery took place. A year later fresh attacks of colic came on and a year and a half later transient sugar was found which, however, soon disappeared. There was still tenderness on pressure on the epigastrium, which pointed to chronic pancreatitis. Probably there was a connection between the pancreatic disease and the gall-stones.

The second case was that of a young man who was struck by a shaft in the epigastrium, and who then fell unconscious; he vomited afterwards. When seen the following day the man had pain, but the general condition was good. The day after, however, he vomited, and the pulse grew worse. Laparotomy was performed, and a transverse rent found in the head of the pancreas. There was distinct necrosis of fatty tissue. After arrest of the hæmorrhage the cavity was tamponaded. The peritonitis, however, went on, and the patient died. The autopsy revealed no injury of any other organ, the case was one, therefore, of an isolated rupture of the pancreas. The fatty necrosis must have been secondary.

Hr. Riese, who took over the first case soon after the operation, was of opinion that the greater part, if not the whole, of the pancreas had necrosed and been cast off.

Hr. Kôte mentioned a case where a patient had diabetes, and died in diabetic coma seven years after operation for necrosis of the pancreas. After death, it was found that the whole of the head of the pancreas had been retained. Whether the diabetes had anything to do with the necrosis of the pancreas was very questionable.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, December 17th, 1904.

### ANGINA ULCEROSA.

At the Gesellschaft, Escherich demonstrated two cases of angina ulcerosa that had been diagnosed as diphtheria before coming to hospital.

This is not an uncommon blunder, and practitioners have good reason to justify the diagnosis when this occurs, as the membranous deposit on the fauces at the commencement of the disease is not at all unlike diphtheria. It is only after a careful examination of the deposit with a microscope, or after a few days have elapsed to allow of the deposit clearing off, when crater-like depressions are observed and loss of substance demonstrated, that it can be proved that it was ulcerative in character and not a simple exudation. He showed two other cases with a deposit that had continued for some time without fever or swelling of glands, but no diphtheritic bacilli could be found in the deposit, except those described by Vincent, which were of a fusiform shape and innocent in character.

### BARLOW'S DISEASE.

This is a commonly recognised disease on the Continent now. Prior to Barlow's description in 1883 the disease was known as "acute rachitis," occurring in the first year, or about the fifth month. The disease is closely allied with scorbutus in the adult, and is therefore dependent on the proper nutrition of the infant, occurring in children fed on artificial preparations, boiled milk, &c., &c. It is not really want of food but rather over-feeding with innutritious food. As the want of fresh vegetables induces scorbutus, so in the case of the infant a lack of fresh milk produces a deleterious condition in the child, as swelling around the epiphyses, hæmorrhages into the subcutaneous tissues, &c., &c.

The child Escherich showed to the members was eight months old, and had been fed on "Biedert's"

artificial cream. It had been sent into the hospital with a diagnosis of spondylitis.

The hæmatoma over the epiphyses of the femur, speno-maxillary bones, and orbit pointed to some justification for the title, but closer inspection, with change of food, soon convinced him that malnutrition was the real factor in the morbid condition. Fresh milk was all that was necessary to effect a cure.

### OVARIAN CYST.

Wechsberg gave the members an interesting account of a cyst which he had removed from a woman, æt. 72. He considered the cyst to be a dermoid which may have been there for some time past, as he could discover no cause beyond a sort of chronic hyperplastic perihepatitis, which had led to a reduction of the liver, though not in the sense of a hepatic cirrhosis. There were no signs present to show how these hepatic changes had come about.

### SPECIFIC AGGLUTINATION.

Schick reported an experiment carried out at the scarlatina hospital laboratory in which a child after one of Bassini's operations for hernia had a large abscess that formed over the new inguinal canal. The streptococcus taken from the abscess formed a specific agglutination with Roser's serum, which is reputed to be an antidote for scarlatina. It was presented in the proportion of one to four thousand. A few others have obtained a similar result with this serum.

### PREGNANCY AND PUERPERAL INVOLUTION.

Halban read a paper on the changes of the uterus in pregnancy, which he divided into physiological and chemical, some of which were benign, others malignant. Of the former, decidual formations, hypertrophy of the uterus, freeing of the vagina, and mammary changes were natural sequences, but renal œdema, pigmentation, and hæmatic changes were always fraught with danger.

According to the experiments of Goltz and Ribbert, the chemical substances in the blood are the real origin of the changes, and are conveyed to the placenta and fœtal organism on which they act. The speaker agreed with the theory, as he had frequently had opportunities to examine uteri and invariably found the fœtus hyperæmic as well as the peri-uterine vessels, muscles, &c., greatly enlarged and distended with blood. Decidual formation was not observed in the experiments, but the mucous membrane had all the characteristics of menstrual changes. In the mammary gland a powerful reaction took place at birth. In the fœtus these changes are also present in sympathy with the mother, as in both mother and child milk will be found in the breast if a female, while hæmorrhage may be met with in both child and mother. It therefore appears that the toxic component of pregnancy passes over the fœtus as well as the mother, as hyper-leucocytoses, nephritic changes, and increase of fibrin were present in both. It seems that this toxin is derived from the placenta and from the epithelial chorion as a secretion common to the two lives, but as soon as the cleavage takes place these symptoms, both in mother and child, cease, and involution commences. The meeting of the spermatozoon and ovum determine the placenta. These fœtal changes are not confined to the female sex, as the "witch milk" of the placental toxin reacts on the prostate of the boy *in utero*, which gradually diminishes after birth, and is always much larger at birth than in children many months older. It is estimated that these active changes in fœtus and mother take place most markedly about the end of the eighth lunar month, when the breasts of the female and the prostate of the male will then be found much larger than in children many months older. We conclude, therefore, that the toxin is equally potent in both sexes alike. In eclampsia, which is connected with the separation of the placenta, the toxin is present in the fœtus in as great a quantity as in the mother.

In the discussion Frankl said that he had made many examinations of the round ligament of the uterus, which is the rudiment of the conus inguinalis of the animal, and constantly found the striated fibres greatly increased and the whole ligament thickened. The

same thickening took place in the foetus in the ninth or tenth lunar months, which is in perfect accord with Halban's theory. He had also observed the great size of the prostate in the male foetus, and would add that the vesiculæ seminales, as well as the pons ampullaris and vas deferens, are also enlarged.

Knöpfelmacher said that he had brought the enlargement of the breasts in the foetus before this meeting two years ago, and suggested then that the milk in the mother was excited by a ferment from the placenta.

Hofbauer agreed with a ferment from the placenta exciting the milk, but doubted the hypertrophy of the genitals in the foetus as these were met with, but were not constant.

## The Operating Theatres.

### ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.

OPERATION FOR CONICAL CORNEA.—Mr. H. B. GRIMSDALE operated on a case of conical cornea. The patient, a woman, æt. 46, had been in hospital for some time previously owing to ulceration of the apex of the cone. With the galvano-cautery Mr. Grimsdale cauterised an area surrounding the apex about 4 mm. in diameter, and thence made a superficial burn to the nearest point of the periphery of the cornea. He then proceeded to cauterise the centre of the circular burn rather more deeply, but, owing to the thinness of the cornea, this membrane was perforated unintentionally before the required depth had been obtained. Mr. Grimsdale said that there were two methods of dealing with such cases: either to produce a scar over the weak area, which allowed the protrusion of the cornea, and thus by supporting it to reproduce the normal curvature, or to excise the weak point of the cornea, and to reform at once an almost normal structure. To deal with this latter method first, it had great advantages; the resulting scar was almost invisible, a single operation sufficed, and often no correcting lenses were necessary, but the risks of the operation were so great that it was rarely justifiable to employ it; a very large open wound was left in the cornea after the excision of the apex of the cone; it was hardly possible, he said, to close this with sutures, and the risk of immediate infection and total loss of the globe was very great. Further, many patients who escaped this suffered prolapse of the iris, and some sympathetic ophthalmia; therefore, he thought, although the results of a successful operation by this method were very brilliant, and better than those which it was possible to gain by the cautery, yet the average results by the latter method were superior. In such a case as the present, where the conjunctiva was obviously not aseptic, it would be under all circumstances unjustifiable to allow the patient to run the risk of an open perforated wound of the cornea. As regards the method by the cautery, he pointed out that there were several modifications; that which he had employed was practically the method of Sir Anderson Critchett. Sir Anderson recommended that the burn of the cornea should be made in successive rings, increasing in depth towards the centre, a form which he compared to a target. In this patient, Mr. Grimsdale said, it had not been possible to follow this method in all points; owing to the thinness of the cornea, the bull's-eye of the target could not be burnt to the depth which had been wished. The accidental perforation entailed a longer convalescence, but probably no other

inconvenience. In extending the burn from the target to the periphery he was departing from Sir Anderson Critchett's method and adopting one recommended by foreign surgeons. The idea was that this promoted the growth of vessels from the surrounding conjunctiva to the central scar, which was therefore vascularised early, and became more stout and resistant. Such a scar necessarily interfered with vision, occupying as it did the centre of the cornea, and it would be necessary at a later date to perform an optical iridectomy to make an artificial pupil to allow useful vision, and probably further to tattoo the central scar so as to prevent the passage of diffused light; this second operation, he said, would not be undertaken for some months, until the curvature of the cornea was re-established.

### ST. BARTHOLOMEW'S HOSPITAL.

OPERATION FOR STRANGULATED FEMORAL HERNIA IN A MAN.—Mr. McADAM ECCLES operated on a man, æt. 43, a German baker, for right strangulated femoral hernia. The patient had had a previous attack of apparent strangulation three days before, but the contents of the sac had then been reduced by taxis. He was subject to chronic bronchitis and had a severe cough, during a fit of which six hours previous to operation the hernia became strangulated. In spite of the lung trouble, Mr. Eccles decided to operate rather than to employ taxis. He advised that chloroform should be selected as the anæsthetic, and this the patient took well. On the sac being opened slightly, blood-stained fluid escaped; within the sac were found two short loops of small intestine lying side by side and tightly gripped by the femoral ring; each was deeply congested, showing marked evidence of strangulation. The stricture was divided and both loops gently drawn down, when it was seen that the constriction had been such as to distinctly indent both loops at the level of the ring, and that the loops belonged to separate parts of the small intestine, a portion of non-congested bowel lying between them. After this inspection both were returned within the abdomen. The sac was dissected up, ligatured flush with the parietal peritoneum, and the femoral ring closed by silk sutures passed from the deep aspect of Poupart's ligament into the origin of the pectineus muscle. Mr. Eccles remarked that there were several factors of interest in the case. The patient, he pointed out, was an undersized man and a baker, both of which circumstances favoured the incidence of femoral hernia, seeing that the occupation leads to severe strain in a stooping position. Femoral herniæ in men, he considered, only account for about 2 per cent. of all protrusions. Operation, he said, was undertaken first because strangulation had already once occurred, and, secondly, from the fact that strangulation by Gimbernat's ligament is apt to be so severe as to rapidly damage the intestine beyond recovery; thirdly, the operation would be a comparatively simple one on account of the thinness of the patient; so that, in spite of the lung trouble, operation seemed to be the least risky procedure. The exposure of the contents of the sac demonstrated the uncertainty that there always is in strangulated hernia as to the exact viscera that will be found nipped. In this case the decidedly rare condition of two separate knuckles of gut strangulated side by side by the same constricting band was found. It was obvious, he thought, that taxis would have been wholly unavailing

both on account of the presence of the two portions of bowel and of the extreme tightness of the ring. The advantage of a close examination of the intestine after division of the stricture was always great, for it was extremely likely in femoral hernia—and particularly so in a male subject—that the almost knife-like edge of Gimbernat's ligament should tend to deeply groove the bowel, which is becoming increasingly congested by the imperfect return of venous blood from its coats, whilst the arterial influx continues.

The bronchitis was not aggravated by the anæsthetic and the wound healed very satisfactorily. A fortnight after operation the patient had an attack of typical lobar pneumonia ending in crisis, but the violent coughing did not cause any giving of the closed right femoral ring.

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### The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 21, 1904.

#### THE LONDON HOSPITAL FUNDS, THE HOSPITALS, AND MR. STEPHEN COLERIDGE.

In a series of articles we propose to criticise the relations of the hospital funds to the hospitals, the medical profession, and the public. The high esteem in which we hold these distributing agencies has been so fully and so frequently professed that there is no need to insist upon the point further. Indeed, it is only the feeling of sincere regard for the future of the Funds that leads to the inquiry whether they are not open to improvement in various directions. The fact that the most important, although the youngest of these Funds, is under the presidency of King Edward VII renders it absolutely certain that every complaint will be carefully and impartially investigated, and that nothing essentially unfair or unjust will be permitted to mar the doings of the Funds. With that conviction well in sight we shall have no hesitation in speaking out our views clearly and impartially. At the outset it may be well to remark that it is extremely difficult, if not impossible, to obtain full information on all points, and if

any of our details should fall short of accuracy we shall be open to correction. The matter, however, is essentially one of principles, and as such must ultimately be settled on those lines. For years past we have asserted in THE MEDICAL PRESS AND CIRCULAR that the public have a right to be informed of the principles upon which grants are made to medical charities. Hitherto the Funds have maintained a silence upon those points as absolute and autocratic as though the administration were in Russia instead of England. Surely in the administration of huge sums of trust money the executive councils of the Funds should proceed on lines of action definitely drawn up and at all times accessible for public information. Our first claim, then, is that the policy of the hospital funds should be openly declared, and that definite information on detailed points of administration should be obtainable by any private citizen. The necessity of some such condition was illustrated last week at the Mansion House annual general meeting of the Hospital Sunday Fund, under the presidency of the Lord Mayor, Sir J. Pound. The Hon. Stephen Coleridge, on that occasion, raised the question of the diversion to medical schools of funds contributed to the hospitals. The speaker was perfectly within his rights in drawing attention to the point, which obviously has a most important bearing on the proper conduct of medical charities. With Mr. Coleridge and his views upon vivisection we have no sympathy whatever, but that fact does not exclude him either from courteous treatment or from an opportunity for expressing his views generally in the columns of THE MEDICAL PRESS AND CIRCULAR. Let us see how he and his friends were treated by the Hospital Sunday Fund. His seconder, the Rev. Mr. Lewis, pointed out an instance of alleged wrongful diversion of funds: £7,000 had been spent by the authorities of the London Hospital for a sports ground for students. The London Hospital has an average annual grant from the Sunday Fund of some £5,000. Any subscriber to that Fund, therefore, is competent to raise the question at a general meeting as to how the money thus awarded is spent by the hospital. Surely the Hospital Fund has a policy on a point of such vast importance to hospital administration. Either it is right or it is not right to allot money subscribed to medical charities upon medical schools. Instead of any official declaration from the Sunday Fund, however, the defence of that body was undertaken by the Hon. Sydney Holland, chairman of the London Hospital, a subscriber to, but not an official of, the Sunday Fund. We have the greatest respect for the conspicuous kindness and genuine disinterested philanthropy that characterises Mr. Sydney Holland. As counsel for defence, however, or as the expounder of a calm judicial analysis of facts and principles, we should regard him as hopelessly out of place. His speech at the Mansion House was, indeed, a warning to all gentlemen who trust to their hearts rather than their heads in

public discussion. He described the remarks of Mr. Lewis as "uncharitable sneers," and said it would have been more generous had the clergyman written him beforehand. "With regard to the sports ground," he continued, "they had the money to invest, and they certainly did not begrudge the sum paid for it. It would, perhaps, surprise Mr. Coleridge and his followers to know that he could sell the sports ground any day for £10,000." All this leaves the main question of Mr. Coleridge unanswered. The point was the right of the hospital to devote charitable funds to the purchase of a sports ground, not as to whether the London Hospital was accumulating money and making sound investments. Nor did Mr. Holland improve his position or that of the Sunday Fund by admitting that the London Hospital authorities had refused Mr. Coleridge's subscription, because it was not sent with the view of doing any good to the hospital (*Daily News* report, December 17th, 1904). Then he went on: "Mr. Coleridge says, 'This money is given to medical colleges which publish no accounts.' Well, we do not supply Mr. Coleridge with a copy of our accounts, because we know the purpose for which he wishes to use them." We submit that such an attitude is insolent and unwarrantable on the part of any hospital committee. Moreover, Mr. Holland was silent when asked whether the accounts of the medical school were sent to any subscriber. The end of this most unsatisfactory discussion was to defer the matter, on the motion of Sir Henry Burdett, until the recently-appointed commission had presented their report. The results appear to show that the Hospital Sunday Fund, although governed by a small and absolutely autocratic executive, has either no decided views with regard to the proper disposition of hospital funds, or, having such views, it is not prepared to announce them in public. Why should not all hospitals, great and small, and all hospital reformers be represented on the executive of the Hospital Sunday Fund? At present the council is a handful of persons deeply interested in particular charities and systems of charities. Its constitution is directly opposed to the enlightened and democratic tendencies of the age.

#### ETHER AND THE BLOOD.

THE examination of the blood is coming more and more to be regarded as an essential part of the clinical investigation of the condition of a patient. Not alone in medicine and diseases affecting the blood, primarily or secondarily, is it thought necessary to have an accurate idea of the condition of the blood, but in surgical affections, and as an indication for surgical operation, its state is regarded as of importance, especially as there is no earlier sign of inflammation than the sudden occurrence of leucocytosis. In order, however, to be able to make use, for diagnostic and prognostic purposes, of the facts gained by examination of the blood, it is necessary to have accurate knowledge of the changes brought about

in the blood by the administration of certain drugs. Of these by far the most important are the common anæsthetics, for their action, if not taken into account, is likely seriously to mislead our judgment on the changes following surgical procedure. It is necessary too, that the physiological action of the usual anæsthetics should be thoroughly understood, and though the action of ether and chloroform on the heart and lungs has received much study, their action on the blood is not known as it should be. During the past few years, however, many investigators have devoted themselves to this field of study, and already we are in a fair way to definite knowledge. Drs. Anders and Boston, of Philadelphia, have published a series of observations (a) on the effects on the blood of the administration of ether in rabbits and in man. In the case of man they have only made use of patients who had not been prepared, either by purging or fasting, for the anæsthetic, as such preparation of itself causes certain changes in the blood. The results obtained are very uniform, and allow certain fairly definite conclusions. The first change noted is a decrease in hæmoglobin, amounting approximately to 10 per cent. during the first twenty minutes of the anæsthetic state. The hæmoglobin reaches its lowest ebb about twenty-four hours after administration of ether, and thereafter tends to return to the normal. This decrease of hæmoglobin explains what has long been known as a clinical fact, that severe anæmia is contra-indicative to prolonged administration of an anæsthetic. Various surgeons have recommended various minima of hæmoglobin, from 30 to 50 per cent., under which they recommend that major operations should not be undertaken. Side by side with the decrease of hæmoglobin, and proportional to the degree of cyanosis accompanying administration, is an increase of the red blood corpuscles. In all cases following on the use of ether there were definite degenerative changes in the red blood cells, mostly associated with the abstraction of hæmoglobin. A fairly constant result, also, of ether narcosis is marked leucocytosis; in some cases the leucocytes were doubled in number, but in all the cells were increased in their normal proportions to each other. This is in marked contrast to what occurs in inflammatory conditions, where the great increase is in the lymphocyte variety.

#### THE REGISTRATION OF MEDICAL STUDENTS.

THE long and somewhat heated debate on the proposal to establish a compulsory register of medical students which took place at the last session of the General Medical Council deserves careful study. The point at issue was sufficiently important in itself, but the mere subject-matter of the debate sinks into insignificance when the larger questions of motive and method are brought under review. The issue really was two-fold—

(a) *Therap. Gaz.*, November 15th, 1904.



namely, whether a Students' Register should be formed, and whether the Council should charge a fee for admission to the Register. It is well known that the finances of the Council have been for a long time past in an unsatisfactory position. The work of the Council has grown, its sessions are longer, and its inspections of examinations are more frequent and thorough. All this means increased expense, and unless funds are forthcoming to meet these expenses not only will the Council be unable to extend its field of operation, but it will be forced seriously to curtail its present undertakings. The matter, then, resolves itself into the following alternatives: Shall the Council grow in power and influence until it becomes the governing body of the profession in deed as well as in name, or shall it sink into the position of an academic body whose function is to keep the Register, to superintend medical education, to record pious opinions, and to furnish the Privy Council with information about the profession when asked to do so? These alternatives may be put in another way. The General Medical Council is the only power-possessing body in the Profession on which the general practitioner has any representation, and, absurdly inadequate as that representation is, the fact remains that it is only through the Council that the general practitioner has any chance of making his views known and his weight felt. Is the general practitioner, then, to be shorn of the modicum of power that is passing into his hands through the increasing influence of the Council, or is the profession in the future, as in the past, to be governed by a number of interested corporations and big-wigs who care little or nothing for the toiling rank and file? This question is contained in the nutshell of students' registration. By extending its power of control over the avenues of approach to the profession, the advocates of students' registration contend that the Council, by establishing such a Register, would gradually be able to define the standards of preliminary education which a student should attain before beginning the study of medicine. Moreover, by instituting the modest fee of one pound for such registration, the depleted exchequer of the Council would be replenished sufficiently to allow of extended work and more complete development. The only alternative means by which money can be raised is either by obtaining an improbable grant from Parliament, already refused; by levying an annual tax on practitioners, which is palpably unfair without a far larger direct representation; by increasing the sum now paid for admission to the *Medical Register*, which is already sufficiently high at five pounds; or, last but not least, by rendering registration compulsory. The establishment of a Students' Register would not only solve the financial difficulty, but would also give the Council authority in a direction where authority is sometimes needed. At the last Session but one, a resolution in favour of asking the Lord President of the Privy Council to introduce a Bill into Parliament

to confer this power on the Council was passed by a majority of twenty-two to six—a mandate quite strong enough for the purpose if it had been allowed to stand. What has been the sequel? No sooner had the Council stated a clear and definite opinion than the Royal College of Physicians and Surgeons of England approached the Lord President by correspondence, protesting against that opinion as an infringement of their rights, and the Lord President in consequence wrote to the Council suggesting that a conference between the Council and the Colleges should take place, so that existing rights might be safeguarded. This letter formed the subject of the debate which resulted in the Council passing a motion to the effect that a reply should be sent to the Lord President saying that the opposition of the Colleges was too strong, and that the Council would prepare an alternative scheme at its leisure. In a word, the Council has caved in completely, and practically acknowledged themselves beaten by the Colleges, not in fair and square debate in the Council Chamber, but by outside tactics. If this is the way that the Council is to be treated, one may well despair of the future. As Sir Victor Horsley—the strongest and clearest-headed man on the Council—pointed out, the Council was appointed by Act of Parliament to be supreme arbiter in matters of medical education, and that position should be recognised by the Privy Council. The licensing bodies are represented in overpowering numbers on the Council, and have every opportunity of making their views known in debate. To suggest a conference is manifestly out of place, as the Council itself is the official conference for matters of this kind: the opinion of the Council embodies the opinion of all the licensing corporations—after full discussion. This the Privy Council does not seem to understand; at all events they treat the Colleges which appeal to them as though they were entitled to be considered on equal terms with the Council. It is a lamentable spectacle for the general practitioner to see the Council, through which alone hope of reform can come, flouted and set at naught by the close corporations which are bent on preserving their privileges. The maintenance of the dignity of the Council and the extension of its authority, together with increased representation on it of the body of the profession, are objects that vitally concern the welfare of the public and the medical man.

### Notes on Current Topics.

#### Preventive Treatment of Cancer.

THERE are few surgeons of wider experience than the Bradshaw Lecturer of this year, Mr. Mayo Robson. It is to be expected, therefore, that the views he has put forward on "pre-cancerous conditions" (a) will attract a good deal of attention. He is of opinion that the onset of malignant disease is preceded by one or other of a

(a) THE MEDICAL PRESS AND CIRCULAR, December 7th.

number of conditions whose presence should suggest the adoption of preventive measures. If this be true, and if these pre-cancerous conditions be capable of recognition, then a great step in the prevention of malignant disease will have been taken. Mr. Robson states in detail several of these conditions, which he regards as leading to cancer. For instance, cancer of the mouth often follows on a chronic ulcer, syphilitic, tuberculous, or dental in origin, or on the irritation caused by tobacco smoke. An old ulcer of the stomach may give rise to carcinoma, eczema of the nipple to malignant disease of the breast, gall-stones to that of the gall-bladder. That all such conditions should be treated is Mr. Robson's opinion, and most of them by the use of the knife. When we ask, however, what is the common feature in which these very varied conditions agree, we are at a loss. In fact, as far as we can see, there is nothing in common but that they give rise to long-continued irritation, and it has been believed by many thinkers that irritation conduces to the growth of malignant disease. But we can hardly think that Mr. Robson suggests that all the conditions he mentions lead inevitably to cancer, or that every seat of irritation is to be removed by the knife. But unless he means this, we are still in the dark as to which of the "pre-cancerous conditions" are to be so treated, and which are not.

#### A Crime of Devotion.

A MURDER of exceptional medico-legal interest took place recently at Droitwich, but we were unable to comment upon it at the time as the murderess was arrested promptly, and our remarks had consequently to be held over till the prisoner had been tried. An old lady, Mrs. Tabitha Lawson, living at Droitwich, had had the prisoner, Mary Holdaway, in her service for forty-seven years, and the two old people—for at the time of her mistress' death Mary Holdaway was sixty years of age—were exceedingly fond of each other. Mrs. Lawson fell ill with some chronic malady that caused her continual suffering, and through her long illness she was tended with slavish devotion and self-sacrifice by her old servant. There can be no doubt about the facts, for in his evidence Dr. Bryceson, Mrs. Lawson's son-in-law, said he had never seen such unselfish devotion as Mary Holdaway showed her mistress. One day, while temporarily alone with her in the house, Mary Holdaway cut her mistress' throat. Dr. Bryceson happened to arrive shortly after, and Mary opened the door, and, clinging to him like a frightened child, kept repeating in a whimpering voice, "Whatever made me do it?" There was no doubt that she was the culprit, and there was no concealment of the facts. Neither was there any motive in the ordinary sense of the word. Counsel for the defence put to the jury the theory that Mary's mind was constantly preyed upon by Mrs. Lawson's suffering, and that her intense love for her mistress goaded her to commit the crime. This the jury accepted, and the poor woman was

mercifully found to be insane at the time of the murder, and therefore not responsible for her actions. Although love has not infrequently acted indirectly as a motive for murder, we do not remember an instance in which it has taken the line it did in this case. The story reads more like the creation of a realistic novelist than one of sober fact, but it must certainly be added to the long list of medico-legal romances that are stranger than fiction.

#### "Grafts."

A COUPLE of years ago there was a good deal of discussion in the American and home journals on the question of the legitimacy of what was called the "division" of the consultant's fee. It was the custom, not, we are glad to say, in this country, for the consultant to return a portion of the fee to the practitioner who had called him in. The good sense of the profession, both here and in America, condemned the practice as being highly objectionable, if for no other reason than that it introduced in the selection of a consultant considerations other than the interest of the patient. Nevertheless, the system has persisted in America, and we learn from our Transatlantic contemporaries that it is by no means unusual for the practitioner to demand a "graft," as it is called, from a particular consultant, in consideration of recommending him. In some cases, indeed, the "graft" is by far the major portion of the fee paid by the patient. For instance, *American Medicine* relates the story of a surgeon who agreed to perform a certain operation for a sum of five hundred dollars. Some time later he learnt that the patient had actually paid two thousand, of which the practitioner had pocketed the balance. We learn from our contemporary that customs such as this are not contrary to business morality in the States, but we trust it may be long before they are accepted by either professional or business men in this country.

#### Bob Sawyer—Ad Nauseam.

ADMIRERS of Dickens—and we are old-fashioned enough to include ourselves among them—are fond of insisting that with all his humour and all his pathos, he was one of the greatest moral influences of the middle of the nineteenth century. No other writer, not even excepting Charles Reade, did more to rouse the public conscience, while entertaining the public intellect; and this great end he was able to accomplish without offending susceptibilities or spoiling a good picture by using too warm a brush. The reason, we take it, was that Dickens was a caricaturist in the truest sense of the word—one, that is, who points his characters with a subtle grace and humour. Just as Mr. Chamberlain is said to be one of Mr. F. C. Gould's warmest admirers, so the medical profession feel that they have no grudge against Dickens for his delineation of Bob Sawyer and his pranks. But there are people, without much humour, we fancy, who out-Dickens Dickens, and find in that clever caricature the eternal type of the medical student. On behalf

of the medical profession we beg to say that we are rather tired of them. In a divorce case tried last week the co-respondent was a medical student of Italian parentage. We have no comments to offer on the merits of the case, which resulted in the jury being unable to agree upon a verdict; but we do protest against the fact of the co-respondent being a medical student being used by the counsel for the husband as an argument in favour of guilt, or, at least, a presumptive element of prejudice. Counsel is reported to have said that the co-respondent was not a child; he was studying for a profession in which wild oats were supposed to be freely sown during student days, to be atoned for by exceptional severity of life afterwards. A speech of this kind is as derogatory to the profession from which it emanated, as its intention was to that at which it was levelled. The study of medicine is at least as ennobling as that of the law, and perhaps it is in consequence of this fact that we ourselves should decline to cast unworthy flouts at future officers of the Courts of Justice.

#### Ethical Pharmacy.

THE prescribing chemist and the patent drug dealer in this country cause sufficient vexation to the medical man who has high ideals as to the methods by which relief should be conveyed to suffering humanity, but surely he would lose his vexation in amusement if they really manage these things in America in the manner described by Dr. Benedict, of Buffalo. From an entertaining paper by him in *American Medicine* (November 26th, 1904), we learn that the city drug-store represents a *bizarre* combination of businesses. It is usually a public telephone office, a branch post-office, express office, place to pay gas bills, sometimes a branch circulating library, and laundry. One can buy candy, hair-brushes, tooth-brushes, soap, valentines, knives, tobacco, soda-water, "soft drinks," and occasional strong drinks. At some stores the attractions include a light lunch, pet animals, and gold-fish. In the midst of what Miss Squeers would call this "delightful embarrassment," there is displayed a notice indicating the *raison d'être* of the establishment in such terms as "prescription counter in the rear," or "prescriptions a speciality." As Dr. Benedict suggests, such a proceeding is about as consistent as if a medical man were to announce that he made a speciality of attending patients. But the competing attractions of the store pale before the whirl of entertainments provided by the shop-windows. Life-size cards remind passers-by of the virtues of plasters "which feel good on the back," and serve partially to hide the charms of ladies and gentlemen in undress. Gigantic green frogs amuse children and call attention to remedies for frog-in-the-throat at the same time, whilst a paste-board trained nurse can be made to advertise nearly anything, and if she can do some automatic feats with a sprinkler or atomiser, she is doubly charming. We rather gather that

there is some difficulty in making one's way to the prescription counter through this hive of industries, especially as to do so one has to pass a series of cures for every disease, neatly done up with directions for use and priced at a cheaper rate than the prescription is dispensed at. In order that the directions may not make too great a tax on the intelligence of the sufferer, they are printed in pamphlets containing information on astronomy, a collection of popular songs, or a complete joke-book. Life for a chemist in America may be busy; it should certainly not be dull.

#### The Dangers of Ice.

A RATHER unseasonable contribution to public health literature is Sir Shirley Murphy's just published report to the London County Council on the way in which the ice-trade is carried on in London. We need hardly say that the report reaches the high standard of interesting thoroughness that we are accustomed to associate with Sir Shirley Murphy's work, but nevertheless it sends cold shivers down the back in more ways than one. At the present season ice as an addition to one's food and drink does not suggest the same comforting ideas that it does in July and August, and we are inclined to think that unless some action is taken on the report even the dog-days will seem more endurable without ice than with it. It is frequently thought that the freezing of water renders it innocuous as regards bacteria, but not only is this not the case, but it has been shown that spores survive even the most intense degrees of cold that can be obtained by means of liquid air. Ice, therefore, unless made from pure water of unimpeachable antecedents, is just as potent and an even more insidious foe than water in its ordinary fluid condition. Apart altogether from the source of the water from which ice is derived, and seeing the facilities that now exist for making artificial ice, Sir Shirley Murphy suggests that all ice for mixing with food and drink should be made from distilled water—there is, to say the least, room for great improvement in the way that ice for internal consumption is handled by dealers. It is hardly unreasonable to insist that ice that is to be put in drinks or placed in contact with fish and butter should be transported in some more cleanly way than the usual one of being wrapped up in filthy bits of sacking in open carts, whence it is often thrown out on a pestilential city pavement.

#### Congenital Word-deafness.

A CURIOUS symptom in the course of certain cerebral diseases is the condition described by Kussmaul as "word-deafness." In this condition patients are unable to understand the meaning of spoken words, even though the hearing itself be uninjured. The occurrence of the symptom is definitely associated with lesion of the posterior part of the first temporal convolution on the left side, and is consequently most often found along with deafness of the right ear. The recorded cases of acquired sensory aphasia of this sort are,

of course, very numerous, but we do not remember previously reading of any case where the condition was congenital. Dr. Syme, of Glasgow, has, however, recently met with a child who apparently had been born word-deaf. He is quite intelligent in other respects, hears sound fairly well, and is able to imitate the sounds made by animals. But he has no idea of the meaning of words, for although he can repeat easy words which are spoken to him, they are never connected with objects in his memory. When first brought under observation hearing was a little dull, but both hearing and speech have been improved by careful training. Dr. Syme is inclined to account for the condition as being due to a faulty development of the centre in the left temporal convolution.

#### The Secret of Secret Remedies.

It is an experience of all of us to have to attend a patient who has been under a course of treatment by some secret cure. He may present a drug rash or some other symptom of chronic poisoning as a result of the treatment, and it is important under such circumstances to have some knowledge of the nature of the drug under whose influence he is. The number of secret medicines, patented and otherwise, in common use is so large that it is impossible for the practitioner to cumber his mind with details regarding all of them. Of the most common it is advisable, however, that every medical man should know something, and such information is notoriously hard to get. In a lecture delivered twelve months ago at the London Hospital, Dr. Robert Hutchison gave many particulars with regard to several of these remedies, naming, as far as possible, the ingredients present in each. One of our contemporaries is starting a series of articles on the subject, and in a recent number (*a*) gives analyses, quantitative as well as qualitative, on the composition of some of the best-advertised cures for epilepsy. It is satisfactory, in a way, to note that none of those examined is likely to be dangerous in itself, since they contain no other drug than those commonly ordered for the disease. The basis of nearly all is one or other of the bromides, the dose in some cases, however, being larger than it is advisable to use without medical supervision. A great contrast is noticed, however, between the price of the preparation and the estimated cost of the drugs used. Two cures which have a large sale at 2s. 9d. and 3s. per bottle respectively are calculated to cost each about one penny per bottle. There is truly no limit to the gullibility of the public.

#### Dogs in Warfare.

CONSIDERING the almost human intelligence of the dog, it has often been a matter of wonder that more use has not been made of him in warfare. That he can be employed for purposes requiring extraordinary intelligence was shown long ago by the monks of St. Bernard, who trained the dogs of that monastery to rescue unfortunate

travellers lost in the snow. Various modern armies have made use of dogs for the special purpose of carrying aid to the wounded, as well as for fulfilling the ordinary functions of sentinels. In the present war in the East the Russians are making use of large numbers of dogs for these purposes. It will be remembered, too, that at the time of the expedition of the allied troops to Peking, much interest was aroused with regard to the dogs attached to the German army. The Germans, indeed, seem to have devoted more attention than any other nation to the subject, and at the annual trainings the Medical Staff Corps are provided with dogs for ambulance purposes. In America, Italy, and other countries dogs are similarly employed. In our own country Major Richardson has for many years endeavoured to persuade the War Office of the advantages to be gained by a proper use of canine help, but so far without success. This year, indeed, having devoted much time and pains to the training of ambulance dogs, he was at length invited to demonstrate his methods in the autumn manœuvres. As a result, General Sir Charles Tucker has recommended the use of dogs trained by Major Richardson's method to the War Office, but as yet no reply has been given. The special utility of the dog is, we believe, in aiding the stretcher-bearers by discovering wounded on the field of battle.

#### "Professor" Alex and the London Hospital.

A HYPNOTIST has recently appeared in London under the title of "Professor" Alex. One newspaper contained a grave account of how he paralysed healthy persons, a phenomenon of suggestion well known to medical science. It has also been scientifically recognised that certain forms of functional paralysis may be made to vanish from a patient under the influence of a strong will. The curable "paralysis," however, must be functional and not organic, that is, it must be due to a mere suspension of healthy nerve action and not to structural changes in brain and nerves. In other words, it is only the, so to speak, mind-created paralysis that can be cured. When, therefore, curiosity-seekers flock to see the palsied made whole, it is well to remind them that the wonders are worked upon defective minds rather than upon the bricks and mortar of our fleshly tabernacle. "Professor" Alex, it need hardly be remarked, is not a qualified medical man. He has stepped over the fence in stating that he has cured "cases which had been discharged as incurable from the London Hospital." His assertion was promptly challenged, but the promise from the "Professor" to correct his mistake from the stage was not fulfilled. The Chairman of the London Hospital, the Hon. Sydney Holland, thereupon wrote to the newspapers denying that any one of the "Professor's" so-called "patients" had ever been in the "London." It is shameful enough that a quack of his kind should be allowed to prey on the public, apart from bolstering up his false pretences by brazen untruths; but after all, there is

(\*) *Brit. Med. Journ.*, December 10th, 1904.

little to choose between one quack and another. The public are being fleeced, damaged and killed on all hands by kindred roguery of the worst possible type. The inherent cruelty and wickedness of the "backache" pill may be taken as an instance. When pain in the back is due to kidney mischief nothing can avert dangerous or fatal results except prompt and skilled medical care. Yet the shameless quack proposes to cure the kidney trouble by nostrums sold at a hundred times their actual value. The humane medical man can only shake his head and murmur a prayer for the poor wretches who are thus deceived. The responsible party is, in reality, the Government which endorses each box of pills for the sake of a paltry stamp fee, and abstains from passing laws to shorten the tether of the quack medicine vendor who sucks the life-blood of the community.

#### Plum-Pudding from all Points of View.

THE part played by plum-pudding in the formation of the national character can hardly be grasped, even in the land of its birth, save by the highest and rarest types of intellect. Its wonder-working charm begins in the nursery, it is continued in the schools, and carried out thence into the busy walks of grown-up life. In all the seven ages of man—not to mention women and babies—it cheers, sustains, comforts, nourishes, soothes, and eke fascinates. Who but an Englishman, born and bred to its toothsome winsomeness, could tell how the essence of plum-pudding has entered into and mellowed and ripened and buttressed the very marrow of his bones? Years ago we wrote of the nutritious virtues condensed in that "speckled globe of savoury delights." Since then base rivals in medical journalism have analysed the atoms of this glorious and hallowed dish with crucibles and test-tubes, and have announced to an indifferent world its precise amount of nutrient matter measured in calorics and what-not scientific jargon. Away with that kind of cold-blooded science! Let the Englishman live for to-day and for ever, happy in the unscientific enjoyment of his plum-pudding. Let us be thankful that in this year of our Lord, although bread and flour and sugar be dearer, yet raisins and currants, on the other hand, be cheaper, while suet and strong ale and brandy and the rest of the dear old classic ingredients, have gone neither up nor down. Let us say, modestly but firmly, of our pudding, *Semper eadem—floreat semper.*

#### Personal Hygiene in Soldiers.

THE alleged physical deterioration of recruits has been supposed to be due to several causes which, reacting unfavourably upon the growth and development of the infant, succeeds in lowering the standard of health in the adult. Many of these—such as overcrowding, mal-nutrition, and parental intemperance—act in combination; and in the preparation of statistics it is difficult to say with precision which factor is the particular predisposing one in any given case. Presuming that

the recruit is of average physique, it is, of course, of supreme importance that he should know how to preserve his body in the highest state of efficiency, both in times of peace and when engaged in active service. The knowledge of hygienic matters possessed by the average "Tommy" is, however, surprisingly small, as Lieut-Colonel H. K. Allport has pointed out in a recent issue of the *Journal of the Royal Army Medical Corps.* The ignorance of the men themselves with regard to such simple matters as the care of the teeth, the prevention of foot-sores, and the need for fresh air and regular washing is only too general, and were it possible to disseminate elementary instruction of this nature more widely a great deal of unnecessary suffering and physical inefficiency might be prevented. The suggestion is put forward that the officers of the Royal Army Medical Corps who possess the necessary training should undertake the task of teaching the men, and if such instruction takes the form of practical demonstrations it is generally much appreciated. Example is better than precept, but without the latter the former often fails to produce the desired impression. Efforts in this direction, as carried out with the Royal West Kent Regiment at Maidstone, were eminently successful in the instruction taking the form of popular lectures in the gymnasium upon elementary physiology and hygiene as applied to the every-day life of the soldier.

#### Signs of Drunkenness.

A MEDICAL practitioner is reported to have stated in Court that "there were no definite signs of drunkenness to guide a medical man." Such an assertion is, of course, perfectly true, for there is not a single symptom of acute or chronic alcoholism, with the possible exception of Quinquaud's sign, that may not occur equally in other morbid conditions. This is a little unfortunate from the point of view of the man in the street, who believes implicitly in the doctrine of "one disease, one sign." Were such universally the case the science and art of medicine would consist of little else beyond a committal to memory of a list of diseases with their corresponding infallible signs. The minds of some of us cannot help reverting to this analogy when we turn over the leaves of some of the excellent medical diaries supplied to each member of the profession by certain enterprising firms. Good as these productions are, we do not desire to see them degenerate into a medical rival of Mrs. Beeton. The diagnosis of alcoholism is some times easy and at others extremely difficult, involving, as it does, a full knowledge of every morbid condition leading to excitement, coma or muscular inco-ordination. The fact that alcohol, in some shape or other, is frequently administered by the friends of a patient in fits or unconsciousness due to nervous or arterial affections further helps to complicate matters. Poisoning by other drugs, and, above all, the possibility of injury to the head with or without visible tokens, have also to be borne in mind. There is no one cardinal sign of drunkenness any more than there is one particular

sign indicative of heart-disease. It is the appearance of a certain "symptom-complex" or group of clinical manifestations alone upon which the diagnosis of alcoholism is based, and he who trusts to one sign only will surely be deceived in this as in every other departure from the normal state.

#### Doyen's Work in Cancer.

THE researches of Dr. Doyen have been considerably discounted among the medical profession in Great Britain owing to the curious secrecy which he has maintained as to methods and details. After the recent action, however, brought against him by an American, whose wife had died under treatment by his serum, Dr. Doyen asked for a responsible medical investigation. That step was taken by the formation of a committee, including Professor Metchnikoff of the Pasteur Institute. Five chief questions are said to have been considered: (1) Does the microbe discovered by Dr. Doyen (the bacillus *neoformans*) exist? (2) If so, is it undoubtedly the cancer microbe? (3) Is it unmistakably distinguishable from other known microbes? (4) Can Dr. Doyen's microbe form the basis for a serum to be used in inoculation? (5) Does Dr. Doyen's serum cure cancer? So far as we can gather the Committee find that the bacillus mentioned was found present in all the cancerous tumours examined, and that the serum has always produced favourable results when administered in inoperable cases. It need hardly be pointed out to medical readers that these statements, assuming their authenticity, are of potential rather than of actual value. It may be that Doyen has succeeded where other investigators have failed—or, again, it may not be the case. Some day the great discovery will undoubtedly come, and the name of another great modern benefactor be added to the roll of fame.

#### A Public Vaccinator as Magistrate.

AS an orthodox medical journal, no one could for a single moment suspect the MEDICAL PRESS AND CIRCULAR of undue sympathy with the anti-vaccination cult. At the same time, anti-vaccinators have their legal rights just as much—no less and no more—than their saner fellow-citizens. If there be one thing more desirable than another in the interests of scientific preventive medicine, it is that the vaccination laws should be administered in such a way as to avoid the least breath of a suspicion of unfairness. It seems eminently undesirable, therefore, that a public vaccinator of a district should be called upon to adjudicate on vaccination cases as a local magistrate. Last week it was reported that Dr. R. R. Brown, of Strood, one of two justices at the Rochester Police Court, directed an order to be made out for the vaccination of a child within fourteen days. The defendant thereupon pointed out that Dr. Brown was favourably interested as the public vaccinator for Strood. The defendant further submitted that the information was bad and the summons irregular. Whatever the ultimate outcome of this case

may be it is obvious that public vaccinators who happen to be magistrates would act wisely in retiring from the bench when vaccination cases come before the Court.

#### PERSONAL.

THE Secretary of the North Wales University College announces that the recent bequest to the college by the late Dr. Isaac Roberts is expected to realise £15,000.

DR. ROBERT WM. BOYCE, Holt Professor of Pathology in the University of Liverpool, sailed from the Mersey on Wednesday last, accompanied by Dr. Evans and Dr. Clarke, as the thirteenth expedition under the auspices of the Liverpool School of Tropical Medicine to the West Coast of Africa. A considerable number of friends, including Professors Ronald Ross and Williams, and the popular hon. secretary, Mr. Alan Milne, assembled on the landing-stage and gave the voyagers a hearty send-off.

DR. HENRY JELLETT has been appointed to the post of Obstetric Physician to Dr. Steeven's Hospital, Dublin, to fill the vacancy caused by the death of Dr. J. L. Lane. The posts of Gynæcologist and of Obstetric Physician have thus been amalgamated.

DR. R. J. ROWLETTE has been appointed Pathologist to Dr. Steeven's Hospital, Dublin.

THE *London Gazette* for December 13th contains the names of four Army surgeons "mentioned in despatches" relating to the Tibet Expedition. Among these the highest in rank is Lieutenant-Colonel L. A. Waddell, C.I.E., I.M.S., a former student of Glasgow University, where he qualified as M.B. and C.M. with honours in 1878, and was made LL.D. in 1885.

ANOTHER surgeon thus distinguished is Major A. R. Aldridge, R.A.M.C., who graduated in 1885 as M.B., C.M., of Edinburgh University, and took the English Conjoint D.P.H. in 1892.

THE third Army surgeon to be honoured is Major C. N. C. Wemberley, I.M.S., also a graduate of Edinburgh University, where he took the M.B., C.M., in 1889.

THE fourth gentleman mentioned is Captain T. B. Kelly, I.M.S., who is F.R.C.S. Edin. (1895) and Licentiate of the Scotch Colleges of Edinburgh and Glasgow. He was educated at Queen's College, Galway, where he was at one time Demonstrator and Assistant Lecturer on Anatomy.

THE Inaugural Dinner of the Association of Medical Diplomates of Scotland will be held in London near the end of January. Particulars may be obtained from the Hon. Sec. David Walsh, M.D., 18A Hanover Street, London, W.

THE retirement of Dr. Trollope is announced from the physiciancy to the Hastings Hospital, a post which he has held for no less a period than thirty-nine years.

AT a meeting of the Court of the University of Edinburgh on December 12th, Principal Sir William Turner announced that, in reply to an appeal to friends of the University for funds to purchase a site for other educational buildings, and for extension of the teaching staff Sir Donald Currie had intimated a subscription of £25,000.

THE Liverpool School of Veterinary Medicine and Surgery was opened on December 13th, by Mr. Walter Long, President of the Local Government Board, who spoke of the importance of this department of study



from the point of view of the physical welfare of the nation, and said that Liverpool was the first university of the country to open its arms to veterinary students.

The next ordinary meeting of the Royal Meteorological Society will be held at the London Institution of Civil Engineers, on Wednesday, December 21st, at 7.30 p.m., when the discussion will be taken on Mr. F. J. Brodie's paper, "Decrease of Fog in London during Recent Years."

LORD RAYLEIGH, we understand, intends to present to the University of Cambridge the amount of the Nobel prize for Physics, which has just been awarded to him.

The Right Hon. Joseph Chamberlain, M.P., will preside at a banquet in London on May 10th next on behalf of the London School of Tropical Medicine.

It is announced that the University of London Unionist Association has invited Sir Philip Magnus to contest the Parliamentary representation of the University at the next Election, and that Sir Philip has consented to stand. The sitting member is Sir Michael Foster, M.D., F.R.S.

A MEETING will be held in the Town Hall, Manchester, on Thursday, January 19th, 1905, at 4 p.m., for the purpose of establishing an institution to promote the social and scientific unity of the medical profession. It is stated that numerous promises of support have been already received. Members of the medical profession are invited to be present at the meeting.

### Special Correspondence.

[FROM OUR OWN CORRESPONDENTS.]

#### BELFAST.

THE OLD ROYAL HOSPITAL.—Since the opening of the new Royal Victoria Hospital last year, the old hospital in Frederick Street has been for sale, and various proposals for its use have been made. The Belfast Guardians now propose to acquire it for a temporary additional workhouse, and at their last meeting it was announced that the Local Government Board had given their consent to the arrangement, provided it can be shown that the premises are suitable for the purpose. The building would provide accommodation for about 400 persons, and it is to be feared that a good deal of additional accommodation will be required during the winter, beyond what the workhouse normally affords. Like all other manufacturing towns, Belfast is at present suffering from bad times and lack of employment for the working classes, though it is hoped that the new electric tramway system construction, which is to be begun at once, will afford employment for a large number of labourers.

THE POLLUTION OF BELFAST LOUGH.—For as long as the oldest inhabitant can remember there have been complaints every summer and autumn of the smell from the slob-land at the head of the Lough, and the warmer the weather the warmer the language used by the oldest inhabitant. Since the present drainage system was introduced the nuisance has become much worse, and an inquiry into its cause made by Professor Letts showed that it was due to the masses of decaying seaweed of the species *Ulva latissima*, which flourishes in the sewage-polluted water. At the instance of one of the rural councils of the neighbourhood another inquiry was held this week, this time by Mr. P. C. Cowan, chief engineering inspector of the Local Government Board. The inquiry seems to be an exceedingly futile one, for it is perfectly well known that the weed grows in sewage water, and that the smaller towns and villages on the shore of the Lough all add their quota to the pollution, in proportion to their population, though, of course, Belfast is the most generous contributor. The only result of the inquiry will probably be a profusion of promises of amendment.

#### EDINBURGH.

EDINBURGH UNIVERSITY IMPROVEMENT FUND.—At the meeting of the University court on the 12th inst., Principal Sir William Turner was in the fortunate position of being able to announce that in response to the appeal made for funds in aid of University improvement, a sum of £40,000 had been promised. Of this sum, £25,000 has been given by Sir Donald Currie, who in his letter intimating the donation, said that he wished the revenue from the sum to be applied to the remuneration of a staff of lecturers such as the University authorities might from time to time appoint, but that, if they found it necessary to do so, the University Court might apply £5,000 of the amount towards the purchase of a site for new laboratories. Sir Donald Currie's desire was to assist in placing the metropolitan University of his native land on a sound financial basis, and at the same time to aid one of the objects of the Carnegie Trust. He had communicated with the Chairman of the Trust, asking that, in view of his gift, the £10,000 voted by the Trust as a capital sum for the endowment of teaching should be paid as soon as possible to the University, or that its income should be made available from the beginning of session 1905-6, and that a further contribution should subsequently be made to University improvement. The chairman of the Executive Committee of the Trust, Lord Elgin, has expressed his sympathy with the object to which Sir Donald Currie's gift is to be applied, and promises to bring the whole matter before the Trustees.

THE REMODELLED LEITH HOSPITAL.—Within the last month the improvements in this hospital, which were begun in 1898 by the building of a new wing to the surgical block, have been completed, with the result that the institution, which has now been almost entirely remodelled, will bear favourable comparison with any other hospital of its size in the kingdom. The last addition has been the erection of a surgical out-patient department replete with every convenience, including a small theatre. A very complete electrical installation has also been put in, including the most recent appliances for high-frequency work. The hospital is an old building, standing in the most crowded part of one of the poorest districts in the city; up till comparatively recent years, all kinds of cases—fever, medical, and surgical—were treated within its walls. To have remodelled, and practically rebuilt the institution so as to convert it into a modern hospital with accommodation on the most approved lines for medical, surgical, and gynaecological cases, including as that did the construction of a nurses' home, the building of new laundries, and a complete reorganization of the working of the institution without having even for a day interrupted the routine of its daily work, was a task of no little difficulty, but now that it has been accomplished it is only just to say that no small part of the credit is due to the indefatigable secretary, Mr. G. V. Mann, whose work for the good of the hospital during a long period of years makes the institution his debtor to an extent which is to be reckoned, not in pounds, shillings, and pence, but in the position which, thanks so largely to him, the hospital now occupies in the estimation of the community.

#### GLASGOW.

THE TREATMENT OF NEURASTHENIA.—At the fortnightly meeting of the Glasgow Southern Medical Society held on Thursday, last, Dr. Thos. K. Munro, Professor of Practice of Medicine in St. Mungo's College, read a paper on this subject. He related some cases to illustrate typical forms of the disease, describing in detail the various forms of the disease—acquired and traumatic—including cerebral, spinal, gastric, and cardiovascular. He considered it was comparatively easy to distinguish between genuine cases of this disease and those of malingering. The prognosis in neurasthenic cases was generally hopeful where the circumstances of the patient allowed of the proper line of treatment being carried out. Dr. Munro advocated the adoption of some hobby by such patients; an outdoor one for

those who were previously closely confined, and sufficient exercise, falling] short of fatigue, at all times. Drs. Carstairs Douglas, Macgilvray, Stewart, Hight, Weir, Halliday, and the President, Dr. James Hamilton, took part in the discussion which followed. Reference was made to the treatment of neurasthenia by means of the high-frequency current. It was recognised that in some cases this modern and fashionable mode of treatment did good. The Weir-Mitchell treatment had, of course, many advocates, but its cost restricted its use to those patients who were in easy circumstances. On the motion of the President, a hearty vote of thanks was awarded Dr. Munro for his interesting paper.

**PROSECUTION UNDER THE FOOD AND DRUGS ACT.**—A medical man in Glasgow, keeping an open surgery with shop on the south side of the river, was last week fined £4, including expenses, in the Summary Sheriff's Court, for selling three ounces of spiritus ætheris nitrosi, which was deficient in ethyl nitrite to the extent of 38 per cent. or thereby. The defence was that the drug was highly volatile, and difficult, to keep, each time the stopper was removed from the stock bottle a certain amount of depreciation took place. It was sold as it was got from the wholesale house. The prosecutor said there was no suggestion of fraudulent intent on the part of the respondent, the whole case being that the medicine had not been properly kept. This action does appear rather harsh of application, and shows that the Pharmaceutical Society is still active, and as this prosecution took place against a medical man with a shop open for the retailing of drugs, we may venture to say that there is great insecurity for others who may be similarly situated. There are certainly many dispensing and retailing spiritus ætheris nitrosi to whom it would never occur to test it, in order to prove that it was of the required or standard strength.

### Correspondence.

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

#### THE LAY PRESS AND THE PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My attention has been called to the appearance in several lay papers of some observations of mine on "temper powders," as if they had been written for the lay Press. As a matter of fact, these are quotations from a paper "On the Use of Salicylate of Sodium and Bromide of Potassium in the Irritable Temper of Cardiac Disease and Gout." This paper appeared in *The Practitioner* of July, 1896, and parts of it having been quoted by one paper without acknowledgment of its source, they were reprinted by other papers. Hence my remarks, intended solely for medical readers, have been supposed to be written for the general public. I regret this very deeply, for I think that had I done this, as many believe that I have, I should have been guilty of conduct derogatory to the profession to which I belong, and naturally am much grieved that I should be supposed to be guilty of this. I regret also that the quotations may do actual harm to health, because the drugs mentioned, though perfectly safe in the hands of the medical practitioner, for whom the paper was written, may prove mischievous in the hands of persons ignorant of their properties.

I am, Sir, yours truly,

LAUDER BRUNTON.

10 Stratford Place, Cavendish Square.

[We sympathise with the annoyance Sir Lauder Brunton has experienced owing to the vagaries of modern journalism. If we remember aright, one of these journalists had the unparalleled audacity to translate the *Practitioner* into the form of a personal interview with Sir Lauder.—Ed.]

#### HOSPITAL FUNDS AND SMALL HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Sewill makes one think of the Heathen Chinese, so child-like and bland. I wonder if he really

means us to believe that every candidate for every appointment at every hospital does not make use of every scrap of influence he has at his command. I would not go the length of saying that every appointment goes by influence, but I have no hesitation in saying that influence helps. It would be ridiculous to believe otherwise.

It is doubtless true that some of the work done at some of the special hospitals is bad, but the same may be said of some of the general hospitals, where, to my own knowledge, the most ordinary surgical principles seem to be completely ignored. Mr. Sewill's advice to abolish most of the special hospitals looks as if he wished to crush out all opposition. He seems to forget that the special hospitals have led, and that the general hospitals have followed. Live and let live is not a bad motto.

As I do not require a hospital appointment, my interest is only that of

Yours faithfully,  
OUTSIDER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am sure you are right in your main contention about the hospital funds. Intelligent interest in the administration and application of the funds cannot be taken by donors or would-be donors, for the simple reason that the information supplied by the Committees under these heads is meagre in the extreme. It should be the aim of these Committees to let the public share all the information that they acquire in their official capacity, and to report fully on their inspections of the various hospitals, when, as in the case of the King's Fund, these are made by authorised visitors. The mischief caused to the funds of withholding such information I can illustrate from my own experience. I had recently under my care a wealthy gentleman, widely known for his donations to philanthropic institutions. He consulted me one day with regard to subscribing to the King Edward VII Fund, the particulars and official publications of which he had carefully studied. I told him all I knew of the work of the Funds, but he was not satisfied. A keen man of business, he informed me that he never gives away a penny unless he is sure that the administration of the financial arrangements of a charity is of the strictest and soundest, as he has often been scandalised by the light-hearted way in which debts are incurred by eleemosynary institutions. Now this gentleman, after a careful study of all available documents, decided that a very handsome sum which he was prepared to subscribe ought to be withheld, as he could not assure himself that it would be used to the best possible advantage. I confess that I felt unable to disagree with him.

I am, Sir, yours truly,

LONDINIENSIS.

December 15th, 1904.

### Literary Notes and Gossip.

THE German Universities provided a very valuable educational exhibition at this year's World's Fair at St. Louis, and the Committee of the Medical Exhibit, of which Professor Waldeyer was President, issued an excellent handbook (German Educational Exhibition, St. Louis: Medicine. Berlin: W. Büxenstein, 1904), which strikingly indicates the energy and scientific enterprise of our German *confreres*, and is well worthy of study by English teachers of medicine.

THE current number of *Tuberculosis*, the official publication of the Central International Bureau for the Prevention of Consumption (Leipzig: J. A. Barth) very appropriately is devoted to the memory of M. Finsen. Among the illustrations is one which admirably portrays our King and Queen at the Finsen Institute.

EGYPT is deservedly a popular land for the health and pleasure seeker, and Assouan has won distinction as one

of its most attractive and advantageous health resorts. Mr. G. Dundas Edwards M.R.C.S. in his "Notes on Assouan," (London: John Bale, Sons and Danielsson), furnishes much practical and trustworthy information regarding meteorological conditions and climatic states which medical men may well study before advising a case to journey to the Land of the Pharaohs. The suggestions regarding the regulation of food, dress, and exercise are judicious, and the section on sun and sand baths contains useful precautions.

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The *Polyclinic* for December contains a lengthy article by Sir Alfred Fripp on the "Radical Cure of Internal Derangement of the Knee-joint."

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DR. DABBS has given us much that is rich in dramatic force and has contributed largely to poetic prose, but throughout his writing there is ever marked the keen clinical instinct of the physician and abundant evidence of the alert mind of the analysing psychologist, mingled with the sympathies of the naturalist and a fellowship born and bred in loving contact with suffering humanity. In his latest essay into the region of romance, "A Sparrow, a Mouse, and a Man: A Study in Solitude" (London: Partridge and Cooper), we have a study of primitive methods as applied in "solitary confinement," and although there is a touch of the whimsical in the story, many points of considerable psychological importance are enforced, and for those willing to read between the lines important practical conclusions will not be hidden.

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THE January issue of "Longman's Magazine" will contain the opening chapters of two new serial stories. The first of which will especially interest the medical profession, as it is written in collaboration by Walter Herries Pollock and his son, Guy C. Pollock, and is entitled "Hay Fever." It is concerned with the adventures of a much and justly respected stockbroker, and is founded on the known action of a drug sometimes prescribed for hay fever; but, naturally, the authors have aimed more at amusement than at scientific accuracy.

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"Who's Who," for 1905, has just been issued from the press by Messrs. A. and C. Black, and is, as its title implies, a biographical record in alphabetical order of personages more or less distinguished from Royalty downwards to the plain Mr. Smith, who is supposed to be endeavouring, or to have endeavoured, to make the world a little better than he found it, when, *mirabile dictu*, without the asking, he was cast on its shores to fight his own little way in his own little time. Of course, in a compilation of this nature some arbitrary rule must necessarily be adopted regarding admission to its pages. Here and there may be found the names of medical men, whilst many are omitted who not unnaturally might consider themselves more eminent. The book is, moreover, not without amusement, we have just lighted on a celebrity thus described: "twice married, now a widower, educated by his mother," etc.

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THE Scientific Press announce that they will shortly publish an "Elementary Treatise on the Light Treatment for Nurses," by Dr. James H. Sequeira, Physician in Charge of the Skin Department at the London Hospital.

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THE ninth edition of Dr. Macnaughton-Jones's "Manual of Diseases of Women," has just been issued by Messrs. Bailliere, Tindall and Cox. In its revised form it is the most beautifully illustrated work on the subject with which we are acquainted, and is *bound* for the first time in one volume or in two, as preferred by the purchaser. We hope to review it shortly.

### Obituary.

DR. ROBERT B. MOORE.

DR. ROBERT B. MOORE, of Rockcorry, co. Monaghan, died on the 12th inst. at the advanced age of 82. Dr. Moore was a native of Rockcorry, and practised there

as dispensary officer for many years. He enjoyed a large and extensive practice, and was looked on by one and all as a very able practitioner. His remains were interred in the family vault at Kilcrow on the 15th, many people attending the funeral from all parts of the surrounding country.

### AN IMPROVED STETHOSCOPE.

MESSRS. SUMNER AND Co., of Liverpool, have forwarded a specimen of a portable stethoscope of an exceedingly workmanlike and efficient pattern. We have tested this instrument carefully, and find it one of the best all-round stethoscopes that we have hitherto seen. The chest-piece has a celluloid diaphragm whereby the sounds are collected and transmitted from the drum to both ears. The whole packs away neatly into a leather purse of reasonably small size, and it is carefully constructed in every detail. One would think the last word had been said about stethoscopes, and that the practitioner had only to choose between the old-fashioned transmitting tube and the modern applied principle of the microphone. Messrs. Sumner's stethoscope, however, shows that there may be excellent half-way houses. The extremely moderate price, a few shillings only, brings it within the reach of all. Students will find this stethoscope excellent for ward purposes.



### Medical News.

National Association for the Prevention of Tuberculosis.

THE fourth annual meeting of the Dublin Branch of the National Association for the Prevention of Tuberculosis was held on Wednesday last at the Royal College of Physicians. The Lord Mayor presided.

Dr. Alfred E. Boyd, Hon. Secretary, read the annual report, which showed that the total number of deaths caused by tuberculosis in its many forms in Ireland during 1903 was 12,180, representing a rate of 2.8 per 1,000, whilst in 1902 the rate was 2.7. Of the 12,180 deaths, consumption was responsible for 9,559, corresponding to a rate of 2.2 per 1,000 of the population. Of these deaths, 4,667 were of males and 4,892 were of females. Of the males who died from consumption during the year, 64 per cent., and of the females 58 per cent., were between the ages of 20 and 45 years. During 1903 tuberculosis caused more than twice as many deaths as were caused by influenza, epidemic diarrhoea, whooping cough, measles, typhoid, and diphtheria together. In the face of these figures, the fact was deplored that the methods by which the death-rate from this cause is being lowered in other lands are still so imperfectly understood and adopted at home. The adoption of the system of voluntary notification of consumption has, on the whole, been productive of but little benefit. The Sheffield Corporation has obtained the sanction of Parliament to a provision which makes notification of consumption compulsory, and the Rathmines Urban Council are now taking a similar step, the result of which will be watched with interest. Both Cork and Belfast have shown much activity with respect to the establishment of sanatoriums for the consumptive poor, but in Dublin matters remained as they were a year ago, and the difficulty of dealing with cases in tenement houses is as great as ever. It was much regretted that the Dublin Corporation have again deferred the appointment of a City Bacteriologist.

Dr. W. J. Smyly proposed, and the Lord Mayor seconded, the adoption of the report. A resolution urging upon sanitary authorities the necessity for making consumption a notifiable disease was then proposed by Mr. Thomas Edmundson, and seconded by Dr. E. J. McWeeney. The officers for the ensuing year were then elected and the proceedings terminated.

## 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.

M.R.C.S.—Our correspondent, in our opinion, having acted in strict accord with ethical procedure, has nothing to reproach himself with.

M.D. (Salisbury).—From the layman's point of view, there was perhaps some justification for describing the late physician named, as an "Eccentric Doctor."

### OUT-PATIENTS AND HOSPITAL LETTERS.

On the first page of each letter is printed in large type, "Keep this paper clean." This office is usually entrusted to the baby, when it tires of hokey-pokey and other refreshments supplied in the waiting-room by sympathetic mothers described as "kind ladies." Another plan is to fold the letter into as small a compass as possible and hold it tightly in a greasy palm, or else to wrap it in the family pocket handkerchief. It is mostly lost when wanted, and the search for it entails a prodigious rummage into pockets, bags, and reticules, during which the doctor fumes and grumbles. Finally it will be triumphantly produced from beneath the baby's under-petticoats.—"Our Hospitals and Charities Illustrated."

BEATUM FULMEN.—Do not engage in any further correspondence, which will be fruitless; but submit the case forthwith to the Medical Defence Union, of which we gather you are a member.

### THE DOCTOR WHO SAVED HIS LIFE.

"One day in Shanghai, when I was feeling sick," says a recent writer on the Yellow people. "I called a Chinaman to me and said, 'John, do you have good doctors in China?' 'Good doctors!' he exclaimed. 'China have best doctors in world!' 'Eudon, do there,' I said, pointing to a house covered with a doctor's signs—'do you call him a good doctor?' 'Eudon good doctor!' he exclaimed. 'He great! He best doctor in China! He save my life once!' 'You don't say so!' I said. 'How was it?' 'Me velly sick,' he said confidentially. 'Me calleo Doctor Han Kou; givee some medicine; get velly, velly sick! Me call Doctor Sam Sing; givee more medicine; me grow worse. Going to die! Bimeby call Doctor Eudon; he no got time, no come. He savee my life!'"

W. WESTERN.—The rumour, as we have definitely ascertained, is without foundation.

AMICUS.—The next vacancy on the Surgical staff will probably occur in two years time—at the hospital in question.

### MEDICINE IN TONS.

Sir Frederick Treves at the Mansion House, London, recently said that in the London Hospital alone they used in the course of a year:

- 1,000,000 pills.
- 3 tons of Epsom salts.
- 3 tons of carbolic acid.
- 14 tons of ether and chloroform
- 10 tons of lint.
- 8 tons of cotton-wool.

While 700 kangaroos supplied ligaments for tendons. In one year, he added, there were 14,384 operations, or forty a day.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY DECEMBER 21st.

ROYAL MICROSCOPICAL SOCIETY (30 Hanover Square, W.).—8 p.m. Paper: Mr. J. W. Gordon: The Theory of Highly Magnified Images.

ROYAL METEOROLOGICAL SOCIETY (Institution of Civil Engineers, Great George Street, Westminster, S.W.).—7.30 p.m. Discussion on Mr. F. J. Bredie's paper on Decrease of Fog in London during Recent Years. Paper: Mr. W. N. Shaw and Mr. W. H. Dines: The Study of the Minor Fluctuations of Atmospheric Pressure.

### Vacancies.

Nottingham General Hospital.—Assistant House Physician. Salary

£100 per annum, with board, lodging, and washing in the Hospital. Applications to the Secretary.

Nottingham General Hospital.—Assistant House Surgeon. Salary £100 per annum, with board, lodging, and washing in the Hospital. Applications to the Secretary.

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.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer.—Salary £130 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

New Zealand.—Professor of Physiology at the University of Otago. Salary £800 per annum, with half of the Class Fees. Applications to the Agent-General for New Zealand, 13 Victoria Street, London S.W.

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.

Dorset County Hospital, Dorchester.—House Surgeon. Salary £100 per annum. Applications to W. E. Groves, Valetta, Icenway, Dorchester.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stok-upon-Trent.—House Surgeon. Salary £110 per annum, with furnished apartments, board, and washing. Applications to the Secretary.

Colliery Club.—Resident Surgeon. Salary £200 per annum. Applications to A. J. Godfrey, Secretary, Vernon Road, Kirby-Ashfield, near Nottingham.

Guildford Borough.—Medical Officer of Health. Salary £100 per annum. Applications to F. S. Miller, Town Clerk's Office, Guildford.

Waterford County and City Infirmary.—Resident House Surgeon. Salary £100 per annum, with board, &c. Immediate application to Cecil J. Wyatt, Secretary. (See Advt.)

## Appointments.

BRAND, ARTHUR MATHER, L.R.C.P. Lond., M.B.C.S., Medical Officer and Public Vaccinator for the North District and Workhouse of the Stratton (Cornwall) Union.

BYRNE, J. P., L.R.C.S., L.R.C.P.I., appointed Senior Resident Surgeon, Provincial Hospital, Port Elizabeth, Cape Colony.

CARR, FRANCIS JOHN HUGHES, M.B. Lond., L.R.C.P., M.R.C.S., Medical Officer to the Dawlish (Devon) Lodge of Oddfellows.

ENGLISH, T. CRISP, B.S. Lond., F.R.C.S., Assistant Surgeon to St. George's Hospital; Lecturer on Operative Surgery, St. George's Hospital Medical School, London.

GAGE, D. P., L.R.C.P. Edin., L.F.P.S. Glasg., D.P.H., Certifying Surgeon under the Factory Act for the Kilmanning (Barth) District of the county of Ayr.

GEE, C. A., M.R.C.S., L.R.C.P., Medical Officer for the No. 7 District by the Shepton Mallett (Somerset) Board of Guardians.

HOYER, W. T., M.D. Canada, Clinical Assistant to the Chelsea Hospital for Women.

LESLIE, ROBERT, W. D., L.R.C.S. & P.I., Resident Medical Officer to the Royal Hospital for Incurables, Donnybrook, Dublin.

RYAN, J. B., L.R.C.P. & S. Irel., Certifying Surgeon under the Factory Act for the Taghmon District of the county of Wexford.

SHEPPARD, J. F., L.R.C.P. & S. Irel., Certifying Surgeon under the Factory Act for the Newport Pagnell District of the county of Buckingham.

## Births.

CAMPBELL.—On December 16th, at 28 North Street, Elgin, the wife of Donald Graham Campbell, M.B., O.M. Edin., of a son.

EASTON.—On December 15th, at 92 Brigstock Road, Thomas Heath, the wife of Harold Augustus Easton, M.R.C.S., L.R.C.P., of a son.

## Marriages.

FOXGROFT—COCKBAIN.—On December 15th, at Christ Church, Sebo Park, Liverpool, Frederick Walter Foxcroft, M.D., C.K. Birmingham, younger son of the late Joseph Foxcroft, Cheetham Hill, Manchester, to Mary Lydia, daughter of the late Thomas Cockbain, Liverpool and Valparaiso.

GRIFFITH BULLMORE.—On December 12th, at Penwarris Church Falmouth, Cornwall, Gordon E. Griffith, of the Colonial Civil Service, West Africa, to Susan Ethel Bullmore, younger daughter of the late Charles Forrester Bullmore, M.R.C.S., L.R.C.P., L.M. Lond., of Helston, and of Mrs. Bullmore, of 11 Stratton Terrace, Falmouth.

## Deaths.

ALLARD.—On December 11th, at 1 Rodney Terrace, Cheltenham Arthur William, eldest son the late Dr. Wm. Allard of Tewkesbury, aged 53.

LOCKE.—On December 6th, at Cawdor House, Botherham, Charles Alfred Locke, M.R.S., L.R.C.P., younger son of John Locke, late of Barbados, aged 40.

SEDGWICK.—On December 14th, at the London Hospital, E. suddenly Norah Emma, daughter of W. Sedgwick, M.R.O.S., of 75 King Edward's Gardens, Acton, W.

TUNMER.—On December 13th, after a long illness, at Leinster Lodge, Fulham Road, London, James Robert Tunmer, M.R.C.S., aged 78.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIX.

WEDNESDAY, DECEMBER 28, 1904. . No. 26.

## Original Communications.

### ON THE VALUE OF THE OFFICIAL REPORTS ON INSANITY.

By W. R. MacDERMOTT, M.B., T.C.D., F.R.C.S.,  
Medical Officer of Poynts Pass District.

THE reader of the comments in the lay press on the official reports of the Commissioners in Lunacy and of the superintendents of the asylums must note in the writers a feeling of bewilderment often ending in naïve expressions of doubt and distrust. The feeling is not at all confined to the lay mind. When medical men, not necessarily in the light of their own technical knowledge, read a few of these reports—for the sake of their own mental stability they should not read too many of them—they cannot but understand and share in the perplexity of the lay reader.

This is apparent even when we take what is more peculiarly within the province of the medical man, the treatment of the insane individual in view of the incidence of the disease. Following Herr Schlagenhausen, Dr. Godsell, Arnold White, and others, though with characteristic moderation, Dr. Rentoul proposes to meet the disease by the sterilisation of *certain* degenerates, with respect to which I must say that, as a medical man, I would kick hard against the onus of having to determine in practice that "*certain*" being thrown on me. On the other hand, medical men too numerous for citation advocate the boarding out or "home" treatment of degenerates—"certain" degenerates, of course—oblivious of the fact that association-intercourse with the insane, is a well-recognised cause of insanity.

It would be unfair to expect in a wide field of observation, and from a body of observers with varying personal equations and limits of study, a uniform statement of fact. In the field of observation of insanity, phenomena or facts, strikingly apparent in one part, are obscure or absent in another, and it is the duty of the individual observer to record the facts within his personal knowledge, but without a knowledge of the whole field he cannot safely generalise from the partial data at his command. A physician in attendance on typhoid cases in a hospital is able to accumulate valuable information as to the disease, but he would be a very acute man indeed if he could from such data give an account of the causation of it in palaces and hovels, cities and countrysides. In the same way the able superintendents of our asylums accumulate valuable information as to the patients in their charge, but their range of observation is not the actual field of incidence of the disease, and therefore we need not look to them for an adequate account of its causation, or even of its general incidence. They give us what we have a right to expect from them. They are hospital physicians—I need not say rather strictly so. They give us what they have to give—experience formed in their hospitals. It would be well if they

told us that they knew little or nothing as to the disease in the country, or as to the circumstances and conditions under which it occurred outside the asylums in their charge.

It would be well if they would tell the Commissioners in Lunacy, Commissions of Inquiry of their several kinds, the Medico-Psychological Association of Great Britain, and all others appealing to them for information, what the information they can give is really worth, and thus enhance the service they render the community, a service of all others the most arduous, difficult, and disagreeable.

They would, indeed, preserve their dignity and efficiency in that position and escape much unfavourable criticism by realising the exact tenor of the requests for information they receive. They will find on reverting to the circulars they have received from time to time from the Commissioners in Lunacy, and to their answers to these circulars, that a competence in them to decide certain questions is assumed which, on reflection, they would not assume themselves. Thus in the Special Report of the Commissioners in Lunacy to the Lord Chancellor (February, 1897), the Commissioners state that they commenced their inquiry by addressing a circular letter to the superintendents of all the county and borough asylums in England and Wales, "asking their views on the subject of the alleged increase of insanity occurring out of proportion to the increase of population in the districts represented by their several institutions, and requesting those of them who were of opinion that such increase had taken place to specify in detail the facts and figures upon which that opinion was based, and the apparent causes of such increase."

Replies were received from 62 superintendents and others, of which 10 were of opinion that relative increase had occurred, 30 that it had not, and 22 declined to give any opinion. Now if the 62 men had a single spokesman he would have said that the general answer was perfectly correct and perfectly worthless, since if relative increase had occurred, it would be a mean quantity the resultant in sum of increasing, decreasing, and stationary terms. He would say that a change of state affecting a minute fraction of population could not be supposed to be uniform over the country, that the answers received correctly indicated that fact, but were worthless as giving an adequate representation of it.

Not even the Commissioners give the superintendents credit for stating collectively the proper answer to a meaningless question. They say: "In some instances it will be seen that no very clear distinction has been drawn between the increase of insane persons, as to which there can be no dispute, and an actual increase of insanity disproportionate to that of population, respecting which there is a wide difference of opinion." Even without this remark the popular mind after its nature would attribute looseness of thinking and want of knowledge to the 62 superintendents, collectively and individually. What it wants itself it naturally takes as wanting generally.

The want of knowledge and looseness of thought are

altogether on the side of those making the inquiry. A superintendent of an asylum is able to say whether the number of insane persons in his charge is increased or otherwise, but he will not infer from increase a general relative increase all over the country or even, as a permanent fact, a relative increase in the district his asylum serves. If the number of cases of typhoid in a hospital doubled, the physician would not infer a general relative increase of the disease all over the country, and any inference he would make as to local incidence would need data apart from the number of cases treated in hospital. The superintendent of an asylum is perfectly justified in merely stating an increase of insane persons in his charge and expressing any opinion he likes for what it is worth as to the cause of the increase. His expression of opinion is no part of his statement of fact, and should not be considered as such.

All these official inquisitions into the prevalence of insanity have the same character. They all go to the asylums and to their superintendents "as scientific experts whose special attention had almost necessarily been fixed on the subject."

The superintendents, and, in general, medical men engaged in the treatment of insanity, however, while scientific experts as regards the pathology and treatment of the disease are not, and would not claim to be, experts as regards facts altogether outside of their range of observation, and which they have no occasion to deal with, or even to consider. If, at the instance of the Commissioners in Lunacy, they express opinions about what they have not considered, these opinions will be taken to mean not inability to form a judgment, but, from their conflicting and contradictory character, as pretension to a knowledge they do not possess.

To understand the false position in which they are placed and the use to which they have been put, they should remember that it has been publicly stated that the authorities do not want any *bona fide* inquiry as to the prevalence of insanity, or any discussion on the subject. It has been stated (*Fortnightly Review*, January, 1893) that the lunacy reports, *i.e.*, the information our superintendents were at the pains to compile, had for years been delayed until Parliament had risen, so that the opportunity of calling attention to them on the Estimates could not arise. Again, the Commissioners in Lunacy in the three kingdoms have been charged with using the argument implied in the phrase, "apparent increase of insanity," in no *bona fide* sense as an argument, but to evade inquiry. I am not here speaking for the superintendents of the asylums, but, as far as I can judge, they cannot be held collectively responsible for the implied argument, now ridden to death. If, however, they have any reason to think that their reports have been, to put it mildly, misunderstood in the past, they may take it as a reason to be on their guard in the future. Here, for instance, is the latest proposal coming from official quarters for an inquiry into the "causes" of increase of insanity in Ireland. The Inter-departmental Committee on Physical Degeneration recommends:—

"That an investigation should be undertaken at an early date into the extent and character of the increase of lunacy in Ireland, and a serious effort made to trace it to causes which might be the subject of some ameliorative interference."

In any such investigation the superintendents of the asylums would, of course, as heretofore, be called on to take a prominent if not exclusive part, with the result that a report would be concocted which would be a *fac-simile* of those already in existence. The report professedly based on the evidence of the superintendents would represent the views of probably not a single one of them, and be as valueless or valuable as its predecessors. The reason is on the surface of the proposal. The logic of causation demands that sequence or change of circumstance shall be traced within integral limits, *i.e.*, the entire limits within which the circumstances can be determined. Insanity in Ireland is no unitary fact, and taking it as such necessarily involves gross fallacy. Thus Irish insanity is ascribed to emigration under the crude supposition that

it drains away the "bone and sinew" of the country. This gross fallacy is, of course, to be corrected by extending the area of inquiry to the United States, and the British colonies, when it will be found that the Irish abroad are as much if not more affected than those at home. Again, in the *British Medical Journal* (October 22nd, 1904), it is stated that "the chief cause of the growth of insanity in Ireland seems to be simply decadence." The Irish population is predominantly rural or agrarian, and if we read agrarian instead of Irish, we will find that in England the agrarian element of population is as "decadent" and as much affected by insanity as in Ireland, the only difference being that the element is relatively a small one. Real inquiry would need this observation to be extended over the agrarian element in Western Europe and in general to all populations having the same form as the Irish and undergoing the same change of state. If the superintendents of the Irish asylums admit that such should be the area of inquiry they should not allow their own narrow local experience to be made the basis of a report which would show them up at loggerheads among themselves.

The limitation of inquiry to "causes which might be the subject of some ameliorative interference" would put the superintendents in a position even more absurd than the limitation of inquiry into a general phenomenon to a particular small area. Of course, the intention is to exclude conventional morality and certain social forms as causes of insanity on the ground that it is useless to touch them. If, however, the old notion that lunacy was due to the moon's state or to an astronomical cause was true, the knowledge of it would enable us to avoid assigning false causes and trying useless remedies for the disease. The diagnosis of disease or its etiology aims at cure and prevention, but is not governed by that aim; as scientific men we are bound to determine causes or antecedents free of pre-conception, and from the mere utilitarian point of view to exclude false causes and *prima facie* notions.

The reports of the superintendents of the asylums can have no value if they are conformed to instructions which violate the canons of scientific evidence, or, in other words, the rules of common sense. I venture to suggest to the superintendents to give their reports in future value by conforming to these rules and refraining from answering inquiries which contradict them.

I may enforce this suggestion by stating the manner in which, as I conceive, an effective investigation into the incidence of insanity must be conducted, which is the manner in which I have myself conducted investigation in, of course, a limited field of observation.

In the first place, what is to be sought is mere description of where and among whom it occurs, its distributional maxima and minima. The causation, or so-called causation of the disease, which is generally hypothesis of effect, should wait on this.

The occurrence of the disease is, as a first step, to be identified in place and time. This can only be effectively done by taking maps of districts and marking houses as representing families contributing cases of the disease within a given period, or by forming an inventory of all the families in the districts and ascertaining the number contributing. As numerical data only are needed, this could be done without violation of private life, but under any circumstances it is not merely childish but criminal in a matter of such importance not to take the only efficient means of determining the actual facts, the only means of getting rid of the dense clouds of falsehood in which the subject is enveloped by men who will not learn, and can never be brought to learn, the nature of *prima facie* ideas.

The value of this method of investigation can be seen at once by comparing, say, the Shankill road district in Belfast with a rural area of equal population in Tyrone or Armagh. In the first-named area there are dozens of public houses, and the population, a working class one, is in a visibly unsatisfactory state, social, moral, and sanitary. In the rural district, wherever taken, there need be no public house, and there is no immorality, illegitimacy, or prostitution, no social misery



and degradation; judged by the death-rate, the sanitary state is very good, and everyone goes regularly to church, chapel, or meeting. Now the man who goes by his *primâ facie* notions would say off-hand that the Belfast district would give the maximum, the rural the minimum, of contributory families. But from personal observation and statistics I believe the Belfast district would be found to give about 10 per cent., and the rural 50 per cent. It has to be noted in addition that the rural group is a pure or unmixed one, while the urban is largely composed of an immigrant rural element.

The method of investigation thus indicated in outline is applicable not only to circumstances of place and time, but to individuals, in whatever way they may be grouped, and thus gives the true logical form for inquiry. The table of causes of insanity of the Medico-Psychological Association is a mere fallacy-trap for our "scientific experts." Thus alcoholism as a "cause" of insanity is not a cause in any true sense, but simply an observation of how many of the insane are found to be under the alcoholic habit. No number, however large, would establish causal relation or an effect. The whole group of persons under the habit gives  $x$  lunatics, but for all we know the numerical value of  $x$  may be less than  $y$ , the figure for the general population, or than  $z$ , the figure for a group not using alcohol at all. I believe  $x$  would be found much less than either  $y$  or  $z$ , not because alcohol prevents insanity, but because the alcoholic habit is a characteristic of a class socially distinct from the group of families giving the maximum of insanity.

In the same way syphilis cannot be proved from numerical data collected in the insane group to be either a cause or effect in insanity. The number of insane in the syphilitic group may, for all we know, be less than the number in any equal non-syphilitic group of the same age-period. This again is due to class distinction; the group of rural families giving the maximum of insanity are almost entirely free from syphilis in Ireland.

Suppose ourselves able to identify anywhere a group of families with specific character and found it increasing, would we be reasonable in stating influences of a destructive nature operating on it as the cause of its increase? Identifying the group contributing to insanity in proportion as we would find it under the influence of alcoholism and syphilis, we would have a cause for its decrease, not for its increase. If destructive agencies do operate, it is by disadvantaging in a higher degree on balance the non-contributory group and so leaving the field to the group predisposed to insanity. In the *Edinburgh Medical Journal* (September, 1903), and elsewhere, I have pointed out that the last-named group is a clearly marked historical one, and is increasing in Ireland and all similar agrarian areas by virtue of the biological law of selection. The group has and had an advantage in its own area and is accordingly increasing. I need not repeat myself here. What is to the point, however, is that as long as I went by the official reports of Commissioners in Lunacy and of superintendents of asylums, I found nothing, in myself, at least, but confusion of mind; not until I consulted the concrete field of observation did I get a gleam of light on the subject. The reports want value because going on worthless *primâ facie* notions of causation and ignoring the whole biological field and the laws operating in it as a whole, applicable therefore to insanity as a partial circumstance in it. Until they take insanity in its environment and under the law of its environment they can reflect little credit on their compilers.

PLYMOUTH BOARD OF GUARDIANS.—At a meeting of the Plymouth board of guardians held on November 23rd, it was decided that a new infirmary should be erected on the site occupied by the garden adjoining the workhouse.

## NOTES ON THE GENERAL MEDICAL COUNCIL AND ITS PROCEEDINGS.

By GEORGE JACKSON, F.R.C.S.Eng..

Direct Representative on the General Medical Council.

As one of the direct representatives of the medical profession for England and Wales, I wish to bring under the notice of my constituents some of the salient points of the matters which have been discussed in the Council at its recent meetings, more especially with reference to the meeting held in November of this year. It may be within the memory of those who have taken an interest in the proceedings of the Council, that there has been a long-standing dispute between the

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS  
OF ENGLAND AND THE COUNCIL,

as to what should be recognised as a sufficient preliminary scientific examination. A report on these examinations was presented to the Council in May, 1903, but the consideration of it was deferred on account of the gravity of it, to a special meeting held in July of the same year. The report was made by Mr. J. Campbell Brown and Dr. Windle. With reference to the first year's examination of the English Conjoint Board, they reported that the standard of the examination was a low one. "The physics portion of the examination amounts to nothing, while the chemistry portion does not afford any assurance that knowledge has been acquired of such a kind as will fit a student to commence the study of physiology, and enable him to understand his reading and acquire a wider knowledge in after life. The syllabus, the details of the paper, the plan of the first and principal part of the practical examination, are at fault, and especially the absence of any guarantee of sufficient preparation for the examinations." The remarks on the examinations of the Apothecaries' Hall, London, and the Scottish Conjoint Board were not so unfavourable, but the standard in each case was considered too low, as was also the case with regard to the Irish Conjoint Board examination, although this examination on the whole was perhaps the best. Resolutions were passed at the July meeting that in the opinion of the Council both the examinations and courses of study recognised by the Royal Colleges of England were insufficient, and the examination of the Apothecaries' Hall was insufficient. In consequence of the representations made to the examining bodies, the syllabuses and the examinations have been very much improved. It is, however, much to be regretted that the English Colleges still recognise as places of study, institutions which are not suitable in the opinion of the Council. It is important that the teachers should be themselves well qualified, that the laboratories should be well equipped, and that the work should be done in the daytime, not at night, as the mental faculties of the students will probably be exhausted by other studies and work during the day.

### REGISTRATION OF STUDENTS.

It is well known that owing to the multiplying work of the Council, the increasing number of the members of the Council, and owing to the greater number of Universities entitled to send representatives to the Council, and to the diminishing number of registrations, the financial condition of the Council is not in a satisfactory state. In

order to remedy this, various proposals have been made from time to time, with the approval of the Privy Council, and a proposition was made and carried by a large majority at the May meeting of the Council, to the effect that a short Bill should be introduced into the Houses of Parliament to make registration by the Council compulsory by students, and that a fee of £1 should be paid by the student.

Unfortunately, at the November meeting of this year exception was taken to this course, and it was evident that the Bill would be opposed in Parliament by the representatives of various corporations, more especially by those of the Royal Colleges of England—those bodies objecting to the Council having the power to register students, and by inference to lay down the conditions of registration. The result was that the Council reversed its resolution of May last and finally resolved to send a reply to the Privy Council—*viz.*, that owing to the opposition by certain licensing bodies, the Council does not desire to ask the Lord President to introduce the measure formerly proposed into Parliament. Personally, I did not agree with this resolution, and voted against it, as did the other direct representatives for England. In my opinion, it would tend to the unification of the system of medical education if one body had the control of the registration of students and their courses of study.

With regard to the financial part of the question, I have always favoured a small annual licensing fee. I moved a resolution in favour of this some sessions ago, but it did not meet with much support. It would have supplied the Council with sufficient funds to carry out its work properly; it would also have brought every practising medical man in touch with the Council, so that if his conduct had not been satisfactory in the past it might be inquired into.

#### MEDICAL PUPILAGE.

At the commencement of the recent meeting of the Council I asked the President to define what was the exact meaning to be attached to the phrase—"The proper training and instruction of *bonâ fide* medical students as pupils"—occurring in the notice regarding the employment of unqualified persons as assistants or otherwise, issued on November 24th, 1897. The President replied in effect that it referred to the fifth year of the curriculum, six months of which may be passed as a pupil to a registered practitioner possessing such opportunities of imparting practical knowledge as shall be satisfactory to the medical authorities. The reason of my asking the question was that it has come to my knowledge that unqualified assistants are employed in numerous cases, more especially in the colliery districts in the North of England, under the guise of pupilage. I ascertained that the Conjoint Board of the Royal Colleges of England does not recognise any such pupilage, and that the English Apothecaries' Hall has had no application for such recognition. It cannot, however, be too widely known that the General Medical Council cannot institute any prosecution in such a case; but that the case must be brought before them by some person or body of persons, such as one of the Medical Defence Unions. It, therefore, now rests with the persons who are acquainted with such cases to take action in the matter. I am informed that medical men generally are not acquainted with the resolution

of the Council referring to the matter, so that it is possible that many are acting in ignorance of it.

With reference to the desirability of reviving in some form and to some extent the old system of pupilage, Mr. Geo. Brown, one of my colleagues as a direct representative on the Council, moved a resolution with reference to it which I seconded, the purpose of it being that students who had served one year's pupilage with a practitioner—who could satisfy the medical authorities that he could give sufficient opportunities of imparting practical knowledge—should be exempted from six months' clinical work at a public hospital. Both Mr. George Brown and myself promised when we were candidates for election as direct representatives on the Council that we would urge this matter on the Council. Unfortunately, it met with little support, Dr. Bruce, the direct representative for Scotland, alone supporting it, in addition to ourselves. The remarks I made on the matter have been partially misunderstood. I did not intend to say that the medical student as a pupil would be taught the art of treating the patient instead of always treating the disease. I wished to convey the idea that the student should be taught the art of treating patient *as well as* the disease, and that he would be more likely to learn that from an experienced medical practitioner than in the wards or out-patient departments of hospitals. I very well remember the late Mr. Arthur Durham sketching out what he thought would be an ideal student's career, and including in it twelve months with a general practitioner, who had large opportunities for seeing practice.

#### FINAL EXAMINATIONS OF THE SCOTCH UNIVERSITIES.

There was an animated discussion on this report, especially on the part referring to the practical part of the examination in surgery at the University of Edinburgh, when it appears that operations on the cadaver are not required from every candidate, but only from those selected, I believe, by ballot, so that it is only fair to say that any candidate may be required to operate. This part of the examination was considered unsatisfactory by the inspector and visitor, who appeared to think that this part of the examining process is usually unsatisfactory, except at Glasgow, where they expressed great satisfaction with it. There is no doubt of the necessity for it, seeing the advances that surgery has made of recent years, and how impossible it is to acquire the requisite dexterity without sufficient practice on the cadaver. It is somewhat noticeable that none of the Scotch universities, except St. Andrews, lay much stress in their examinations on knowledge of diseases of eye, ear, throat, nose and skin, but at this University there was an elaborate examination in these diseases—well arranged, and on all points satisfactory. In the end it was decided that there should be a re-inspection of the final surgical examination of the University of Edinburgh. There is no doubt but that this University suffers from a plethora of students, and in consequence a lack of teaching material.

#### MEDICAL COMPANIES BILL.

This is a matter of extreme interest to the medical profession at large. It arises, as is well known, from the fact that seven persons can combine and form a company and do that which it is unlawful for one man to do. This practice has

received a check by the judgment of Chief Baron Palles, in Ireland, by which the Registrar was interdicted from registering a company, but, as Sir Charles Ball remarked, a company may go on for ever, and therefore it is necessary to deal with the companies already registered. An attempt in that direction is being made in Ireland, but the matter is at present *sub judice*. The Council has communicated with the Lord President of the Privy Council on the matter, expressing the hope that the Government will take such steps as may be necessary to prevent the provisions of the Medical and Dental Acts being evaded by persons improperly taking advantage of the provisions of the Company Acts.

The penal business of the Council does not appear to call for any especial comment, substantial justice being done in each case.

### French Clinical Lectures.

## PERIODIC PARALYSIS OF HEREDITARY ORIGIN.

By DR. L. CHEINISSE,

Late House Physician to the Montpellier Hospital.

[SPECIALLY TRANSLATED FOR THE MEDICAL PRESS AND CIRCULAR.]

SOME twenty years ago Professor Westphal published "A Remarkable Case of Periodic Paralysis of the Four Limbs Associated with Disappearance of Electrical Excitability." Discarding the possibility of its being of malarial origin, the author described the case as probably unique, although a Russian observer, three years before, had brought forward a case of "Intermittent Nervous Spinal Paraplegia" closely resembling that of Professor Westphal's. In Dr. Chakhnovitch's case, the motor disturbances appeared and disappeared during the night, leaving merely an ephemeral numbness of the extremities. It is worthy of note that the father of this patient appears to have been similarly afflicted in childhood and succumbed to an attack of the kind at the age of 54. On comparing the symptoms in the two cases it is obvious that they are similar, but Westphal's description gives greater prominence to one of the most remarkable features of periodic paralysis, *viz.*, the complete loss of electrical excitability without any trace of degeneration in the paralysed muscles during the persistence of the paralysis. Although periodic paralysis is a rare affection, it is something more than a pathological curiosity. The literature of the last twenty years contains a certain number of cases which suffice to show that it is a morbid entity with well-defined clinical manifestations. In its typical form the attack is characterised by the onset of paralysis with diminution or complete loss of electrical excitability and of the reflexes, without any concomitant sensory or intellectual disturbances. In contrast with paralysis of malarial origin the recurrence of the attacks is governed by no law of periodicity: sometimes they occur daily, in other instances the attacks are separated by a longer interval. In a case recorded by Dr. Goldflam, the attacks occurred once or twice a week in summer and every two months in winter. There may apparently be a single attack, as in the mother of Goldflam's first patient, who had her first and only attack at the age of 36. As a general rule the attacks are occasional at the onset, increasing in frequency later on, and after persisting at a high level for many years they begin to diminish in frequency. The duration of the attacks varies, not only in different individuals, but even in the same person. Usually lasting several hours, they may persist for days or may subside in a quarter of an hour.

The paralysis often supervenes during sleep, the patient, on awakening, discovering that he is unable to move. When it supervenes in the waking subject

it is ushered in by sundry preliminary phenomena such as weakness in the limbs, a sensation of fatigue, drowsiness, pricking, formication, intense thirst, &c. According to Dr. Cousot, the attack is not always complete from the onset. The patient may be engaged in copying and the paralysis only attacks the unoccupied limbs, the active limbs only being affected when work is relinquished. A sharp walk may, in the same way, delay the extension of the paralysis to the legs. Speaking generally, repose is as favourable to its development as active exercise is contrary thereto. The influence of immobility in favouring the onset of the paralysis has been clearly described by Goldflam, who was able to induce an incomplete attack of paralysis of all four limbs, with loss of electrical excitability, &c., merely by keeping the patient for some time in the sitting posture. Some authors, however, have observed attacks following great physical fatigue, but even in these cases the paralysis only supervened after a period of repose.

Even if incomplete at the onset the paralysis rapidly extends. As far as one can judge it usually commences in the lower limbs, thence extending to the trunk and upper limbs, but in some instances it began in the arms or hands. In one case the paroxysm was precipitated by the prolonged pressure of the hands on the handles of a bicycle.

It is but rarely limited to the lower limbs, and, as a rule, the paralysis involves all four limbs and the muscles of the trunk. When it invades the respiratory muscles the patient complains of a difficulty in sneezing and coughing. Occasionally the muscles of the neck are also involved, interfering with the head movements. It but rarely happens that the lingual and pharyngeal muscles are affected, although Westphal and Cousot both observed disturbances of swallowing and speech. In a case recorded by Dr. E. W. Taylor, the motor branch of the fifth nerve was slightly affected during severe attacks, but usually—and this is one of the distinctive characters of the malady—the cranial nerves are unaffected. Even when all the voluntary muscular system participates in the attack, the movements of the eyes and facial muscles remain intact. The unstriated muscles also appear to escape invasion, and the constipation observed in some instances was probably due to loss of the action on the part of the "abdominal compressors" rather than to any paresis of the intestinal muscles. Dr. Taylor, it is true, notes complete absence of micturition in one case during the attack, although this lasted thirty-six hours, but he admits that it could not be described as retention, but was due rather to the absence of any desire to water, dependent, partly, on reduced renal activity, and possibly also the patient's difficulty in moving himself.

The severity of the paralysis varies within wide limits, the motor disturbance amounting to anything from mere paresis to absolute paralysis. Speaking generally it is less pronounced in the upper than in the lower half of the body.

One of the most distinctive and important features of this form of paralysis consists in the temporary abolition of faradic and galvanic excitability, in a degree corresponding to the severity of the attack. This affects the nerves as well as the muscles. This symptom, as Westphal remarks, is "unique of its kind," for it is never met with in any other disease of the spinal cord or of the spinal nerves, and it had been observed in every case of periodic paralysis in which the electrical test has been applied. When the muscles are completely paralysed, not the slightest contraction can be obtained, no matter how powerful the current; in less marked cases the excitability is diminished *pro tanto*. In the course of an attack certain groups of muscles may still react to the electrical stimulus, while others are absolutely indifferent thereto. Dr. Goldflam notes that the idio-muscular excitability, like the electrical excitability, diminishes in proportion to the severity of the attack, and may, similarly, be totally abolished.

The deep reflexes are almost always diminished or

abolished during the attack, but the superficial reflexes are less constantly affected. These disturbances, indeed, depend merely upon the distribution and the intensity of the paralytic phenomena. Since the lower limbs are almost invariably more markedly affected than the rest of the body, it is easy to understand that the patellar reflex is wanting in most instances, and that the abolition of the plantar reflex is more frequently observed than that of other cutaneous reflexes.

The paralysis is usually flaccid, with complete resolution, but Chakhnovitch and Greidenberg have noted a certain degree of contraction in particular muscle groups. The extent and the severity of the motor disturbances present a striking contrast with the absolute integrity of the special senses and of sensation. At most, and then only at the onset, have pricking and formication been complained of. In one case recorded by Fischl, however, some loss of sensibility was remarked.

Just as the onset of the paralysis is gradual, so also it tends to disappear piecemeal. As a rule, the mode of subsidence is inversely to that of the onset, in such wise that the upper limbs are the last to lose and the first to regain their motility. Electrical excitability is restored *pari passu* with the return of movement until it is at the normal level. According to Cousot, galvanic excitability is the first to return as the muscles regain their contractility. However this may be, the electrical reactions between the attacks appear to be quite normal, although in one instance Dr. Goldflam noted some loss of electrical excitability in the small muscles of the hand which he was inclined to regard as evidence of degeneration. It should, indeed, be borne in mind that between the attacks most patients suffering from periodic paralysis enjoy perfect health and present nothing abnormal.

As will be seen, the schedule of symptoms just described comprises sufficiently distinct and constant characteristics to enable us to differentiate this affection easily enough from malarial paralysis. Moreover, in order to avoid any possible error of interpretation, I have deliberately left on one side all cases that could by any possibility be ascribed to malarial influence. For this reason I have ignored Cavaré's cases as well as those of Hartwig and Gibney, either on account of the beneficial action of quinine or of malarial antecedents, and this independently of the fact that, with the exception of Hartwig's case, none of these cases exhibited the symptoms of periodic paralysis as described above. There were disturbances of sensation, febrile reactions with attacks of shivering and heat, &c. For the same reason I have thought it well to discard an otherwise interesting observation by Seiler as well as cases by Bataille and Rockwell, which were examples of intermittent hemiplegia, probably of malarial origin, judging by the excellent effects that followed the administration of quinine.

The periodic paralysis, of which numerous examples, have been mentioned, as I have pointed out, has nothing to do with intermittent fever, and it is equally independent of malarial cachexia, since the cases which I have instanced were observed in healthy subjects free from any malarial antecedents. It remains to be seen whether any other infective malady may or may not play an active part in its etiology. Looking closely at the facts before us, this appears improbable. The only infective malady which has been met with in the antecedents of several of the patients suffering from periodic paralysis is scarlet fever. But, with the exception of Fischl's case, the fever was long anterior to the onset of the paralysis, and the virus of scarlet fever is not operative at such long intervals; moreover, paralyzes consecutive to scarlet fever, rare in themselves, are almost always cerebral.

With regard to the predisposing causes of the disease, sex does not appear to exert any influence, but it is quite otherwise in regard to age, the affection supervening almost invariably during adolescence, *i. e.*, between 10 and 25 years of age. One of the most interesting features of the disease is its family or hereditary character. This was noted by Chakhnovitch,

but was particularly emphasised by Cousot, who, out of eight children belonging to the same family, found four suffering from periodic paralysis, as did also their mother. Goldflam, moreover, insists on the family character of the malady, his remarks being based on observation of eleven members of one family. Taylor's two patients were brother and sister, and in five generations on the maternal side there had been no less than eleven cases of periodic paralysis. It is curious to note that the disease was almost always transmitted directly, that is to say, the members of the family who were themselves free from paralysis begot children equally exempt therefrom.

These facts deserve our careful attention, if only for the reason that no history of disease of the nervous system was discovered in this family any more than in that of the family referred to by Goldflam, beyond the occurrence of epilepsy in one member thereof, this one, as it happens, being free from paralysis. This fact does not diminish the importance of the rest of the series since it is established that periodic paralysis had shown itself in three successive generations of a family apparently exempt from any other neurotic tendency. The same family characteristic was noted by Hirsch, Mitchell, Buzzard, Oddo, and Audibert, so that it may fairly be described as an hereditary affection.

Under these circumstances, it appears reasonable to place periodic paralysis in the group of family diseases along with primary progressive myopathy, congenital myotonia, &c., the more so seeing that, from a clinical point of view, the paralysis in question presents certain points of resemblance with Thomsen's disease. We must take note, on the other hand, of the anatomical observations made by the same author on small, freshly-excised fragments of muscle. By this means Goldflam was enabled to satisfy himself of the existence of certain changes (hypertrophy of the muscle fibres, wasting of the primitive fibrillæ and vacuolisation), which are also of a kind to bring periodic paralysis into line with congenital myotonia. These observations have, moreover, been confirmed by MM. Crafts, Singer, and Goodbody.

However this may be, it is hardly possible for us, at this stage, to accept the hypothesis formulated by Chakhnovitch, according to whom this paralysis is merely a simple neurosis, involving more particularly the antero-lateral columns of the cord. The explanation offered by Cousot, who endeavours to show that the transitory paralysis is due to a sort of inhibition of the medullary centres, hardly commends itself for adoption, although a very similar hypothesis has quite recently been put forward by Putnam. The view that we have here to deal with an affection, strictly speaking, of the muscles is supported not only by the analogies of periodic paralysis with Thomsen's disease, and the presence of the above-mentioned muscular lesions, but also by the case recorded by Bernhardt, in which the attacks were associated with progressive muscular atrophy of the hereditary type. Moreover, even if we admit this explanation, it still remains for us to discover the cause of the morbid process thus attacking the muscular element.

According to Goldflam, it is due to a variety of auto-intoxication by substances that accumulate in the organism in the state of repose, an hypothesis which he has tried to substantiate by experiment, *viz.* by injecting animals with urine secreted during the paralytic attack. He discovered that the co-efficient of urinary toxicity was much higher during, than between, the attacks. He found, on the other hand, that the disappearance of the patellar reflex, which only takes place just before death in animals injected with urine passed *between* the attacks, is, on the contrary, an early symptom when urine passed *during* an attack is employed; the same remark, indeed, applies to the paralysis of the extremities. These experiments, however, gave no result in respect of the electrical excitability of the muscles.

Although the outcome of these experiments is far from conclusive, since Goldflam failed to reproduce experimentally the characteristic syndroma of periodic

paralysis with loss of electrical reaction, we are fain to admit that the hypothesis of an auto-intoxication is the most plausible and the best calculated to explain the paralytic phenomena and the injurious influence of repose (delayed elimination of toxins).

The etiology and pathogenesis of this affection being still obscure, we must not be surprised to find that the influence of the various therapeutical agents employed to combat it (bromides, iodides, strychnine, eserine, galvanism, &c.) should be in great measure negative. In view of the injurious influence of repose in the production of the attacks we might try massage and suitable gymnastic exercises as soon as the prodromal manifestations indicate the proximity of an attack. Nevertheless, it is difficult to avert the attack, and as a general rule the most we shall achieve will be to delay its supervention. Lastly, if one bears in mind that, according to Oddo and Darcourt, muscles faradised during the attack resume their motricity more promptly than untreated muscles, it might be worth while employing the current for a sufficiently prolonged period to the paralysed muscles during the attack.

## RECORD OF A CASE OF TUBERCULOUS SYNOVITIS OF THE RIGHT KNEE-JOINT

IN A BOY, ÆT. 8; ACCOMPANIED BY A NEW  
SUGGESTION AS TO THE PART PLAYED  
BY FOOD IN THE HUMAN ECONOMY (a)

By A. RABAGLIATI, M.D., F.R.C.S. Edin.

H. L., æt. 9 last March, was first brought to me on January 6th, 1904. He was pale and thin, and also limping. On examination I found a swelling of right knee-joint, the whole synovial membrane being thickened, so as to fill all the hollows of the joint with a gelatinous, more or less elastic feel all over it, while at the upper and outer part of the sac there was a special thickened and resistant part raised in the form, and about the size of a cricket ball. Whether this portion of the thickened sac was loculated off from the rest of the synovial apparatus was not certain. No fluid wave could be propagated from one part of the sac to another. This question was settled at the operation. There was no demarcation, although preparations were being made by Nature with that end in view (or at least adapted to that end). Had suppuration been allowed to occur, no doubt the suppurating part would have been more or less demarcated from the rest. However, when I saw the boy first, I did not think that operation would be necessary, and as I was very anxious to avoid interference, which would almost certainly have opened the joint, I recommended that the boy should go for treatment into the Children's Hospital. The limb was laid on a back splint, the knee being surrounded with strips of Scott's dressing pulled moderately tight, so as to give support. For diet I ordered a pint of milk daily, divided into four portions, to each of which an equal quantity of boiling water was added. I believe that tuberculosis is a disease caused by over-feeding beyond the requirements of the body; hence my recommendation that the boy should have only as much food as would be represented by 280 calories a day, in place of the 1,200 or 1,400 which the physiological authorities say is necessary for him. And the definition I venture to offer

of the disease tuberculosis is *not* that it is a condition caused by the growth of the *Bacillus tuberculosis* in the tissues and blood of the patient, *but* that tuberculosis is that state of the economy which favours the growth of *Bacillus tuberculosis*. The boy had been very delicate all his life. His parents thought they would not be able to rear him. He was continually taking cold, terrifying his mother by waking up in the night with attacks of spurious croup (*laryngo-tracheo-bronchial catarrh*). The least exposure or exertion seemed to give him cold. I think, in this connection, that in treating delicate children we forget that the definition of delicacy is that it is a state of low resistance to all sorts of labour, and, among the rest, to digestive labour. In our desire to feed such children sufficiently we over-do and over-feed, I think, and the children suffer from the excess of our zeal. Delicate children ought not to have their digestive resistance over-taxed any more than that of any of their other powers.

The child did not settle well away from his mother and family, and it was agreed that he should be taken from the hospital on January 24th, 1904, and treated at home. The diet recommended was, for a time, the same as in the hospital, and by-and-bye the same with half a pint of soup, brown or white, at dinner-time, with some cooked green vegetables and half a slice of bread. Total caloric value say 350 to 400. He did very well on this diet. All the pain disappeared with rest, and as there were no constitutional symptoms, I hoped for an improvement in the knee also. This hope, however, was disappointed, for after some weeks the knee was not better and, indeed, it seemed as though an abscess would be likely to form at a considerably later date. As at last I did not see any sign of subsidence of the tumour, and as I had seen an almost exactly similar case in which suppuration had occurred, which had penetrated through the synovial and muscular tissues even to the femur, I recommended that an operation should be performed for the removal of the portion of the sac chiefly affected. I was glad I did, for when, with the kind assistance of Mr. Miall, I cut down on it on February 20th, I found that the general synovial sac was thickened, that the special part of it which may be called the tumour was specially so, and that it seemed to be intimately adherent to the vastus muscle and other parts of the quadriceps extensor, and also that the contents of the synovial sac, and especially at this place, were of a dark grey or almost black colour. I felt convinced that it was not likely to resolve, and that, in fact, the condition was in process of eventuating in the formation of suppuration, which from former experience I felt sure would not have stopped till it reached the femur. I emptied the contents and removed the bulging part of the sac, which was about the size of an orange, bringing the edges together as well as I could with catgut sutures, the whole operation being done under aseptic conditions as far as possible, although, as you may perceive, I attach far more importance to *internal asepsis*—i.e., to proper nutrition—than to those multitudinous external ablutions which pass under the name of asepsis. I examined the inside of the joint with the finger, but found no ulceration of cartilage. Then I brought the whole wound together with silkworm-gut sutures, passed deeply, after having made the parts as dry as possible by pressure between

(a) Read before the Bradford Medico-Chirurgical Society, November 15th, 1904.

mops wrung out of Hg.I<sub>2</sub> solution 1 in 5,000. The recovery was satisfactory. Even during the first day and night the pain was not intolerable, and I used no morphia. On March 11th, there were no signs of constitutional disturbance, although there was a considerable amount of suppuration about the wound and the exudation of some tuberculous pus. On March 28th, I asked Mr. Miall to give me his opinion again on the whole case. The wound was then nearly well, there being only one small granulation excrescence remaining at the upper part. The patella was free and movable, as it has remained ever since. The hollows of the joint showed very much as on the other side. Boy looking well; no fever; sleeping well; eating well; bowels acting. Diet, a pint of milk daily, with half a pint of soup and a slice of brown bread. I had removed the back splint on March 24th, and asked the mother to bandage the limb afresh morning and evening. Total calories from food as far as I could gauge them, not more than 500, against the 1,200 or 1,400 recommended to an ordinary child of that age, or the 2,000 or more recommended under prevailing ideas as suitable for a child suffering from a wasting disease like tuberculosis.

Now, in case any gentleman may say or think that this was not a case of tuberculous, but only of simple inflammatory synovitis, I have to mention that I sent the boy again to Mr. Miall on account of a strumous irido-keratitis which was very severe, and accompanied by so much photophobia as to induce temporary functional blindness. Mr. Miall thought that it would be well to take the opinion of a specialist, whereupon the boy was sent to Dr. Little in May. Dr. Little may remember the case. At any rate, he confirmed the diagnosis of strumous keratitis and iritis, and gave a hopeful prognosis, which has been verified, the boy being now almost well, and having been able to attend school since the beginning of the autumn term. The knee has been quite cured long since, the boy being able to walk and even run a short distance without limping. I do not know how it might be if he ran for a long distance, but at any rate he does everything which his companions do at school. (a) He is in no sense an invalid, and his parents say he is stronger and has fewer colds than ever before in his life, and has, in fact, been converted from a delicate boy, constantly ailing with colds, bronchitis, &c., into a boy who, if not exactly robust, never ails anything. The cough which used to wake him up in the night never troubles him at all now. His diet on one day last week, taken at random, was: in the morning, on going out to school, a cup of cocoa. His mother mentioned as a point of interest that he never seems cold on this. At dinner he had an egg (sometimes he takes a couple of ounces of mutton) and a slice of bread, say two ounces, and about 1½ inch square, or say 2½ square inches of a fruit pasty. In the evening he had another slice of bread and butter, a glass of milk, and about ½ oz. to 1 oz. of cheese. The caloric value of this, so far as I am able to gauge it, is about: Bread, 138; bread and butter, 208; egg, 70; pasty, say 70; cheese, 112; milk, 280 calories—total, 878 calories, if, indeed, he had as much as this, for I do not think he took a pint of milk, and I doubt if he had as much as an ounce

(a) His mother has since informed me that the boy does not limp at all, even if he runs a long distance.

of cheese. For many months he took only the morning cup of cocoa, a slice of bread with soup at dinner-time, and half a pint of milk in the evening, a diet amounting to the value of about 350 calories, and which I call practical monositeism. He is now dissiteous, and I have advised his mother to keep him to this. He has gained about a stone in weight since I saw him in January.

Now, gentlemen, I come to the second and main part of my communication. I will put what I have to say in the form of a suggestion. It has been suggested to me, (a) and I in turn suggest to you, that we ask ourselves the question, Is food to any extent, and if so, to what extent, the source of the external energy exerted by the body?

Do not please put this question aside as unworthy of consideration. It will be put to you, I venture to say, on other occasions than to-night. I want to ask whether the analogue of the human body considered as a machine is not rather the electric motor of the electric engineer than the steam engine of Watts; suggested as an analogy by Liebig and Playfair, Moleschott, Ranke, and the rest of the modern authorities. The difference is enormous. If the analogy is the steam engine, then the body gets the energy which it exerts externally (and which, for the sake of brevity, I shall call its external energy), from the potential energy of its fuel; and food is the fuel. But if the analogy is, properly speaking, not the steam engine but the motor, then the body gets its external energy not from its food or fuel, but through the analogue of its wires, or even wirelessly—*viz.*, from the illimitable stores of energy with which in Nature it is surrounded. Let us think of this. It seemed incredible at first, but the more I think of it the more does the idea fascinate and hold me. What seems to me to be the truth is this: *Qua* internal energy—*i.e.*, so far as nutrition and the maintenance of the animal heat are concerned—the body does seem to be analogous to a steam engine, and gets its energy for these two purposes from the food. The maintenance of the animal heat is a serious task. The body of a man weighing, say, 120 lbs., has to be maintained at 40° or 50° or 60° F., above that of the surrounding atmosphere. Even if the specific heat of animal tissue is the same as that of water, this implies an important amount of work. Some years ago, I made out from somewhat rough experiments that the specific heat of animal tissue was about 780 foot pounds. If this is nearly correct, the internal energy of the body will amount (besides the energy of simple nutrition) to  $\frac{120 \times 60 \times 780}{2,240}$  or about 2,500 foot tons of energy, a very considerable amount; and it is for this purpose that I believe food to be necessary for the body. But the *external energy* of the body, I suggest to you, does not come from the food, nor even from the body. It comes from those stores of energy with which the body is surrounded, and in which it lives and moves. This idea does not contravene the law of the conservation of energy. The body no more creates its external energy than the motor does. Like it, however, it transmits and transforms the energy which it receives. I have said what is the function of food; and the function of the engineer or owner of

(a) By Mr. Hereward Carrington, of New York.



the body—*i.e.*, of each person, is to see that all the points of contact, so to say, of the machine, all its electrodes and avenues and channels, are bright and clear, so that there shall be as little hindrance as possible to either the inflow of energy in the form of power, or to its outflow in the form of work done. If the internal work of the economy is either underdone or overdone, its work as a motor must be interfered with. If the nutrition is too little, the receptive power of the motor will be checked and unduly diminished. If the nutrition is overdone, then the receptive power will also be diminished, because the points of contact or the electrodes will be dull and clogged. And when the nutrition is properly managed, the motor will work up to the measure of its capacity, receiving as much energy as will fill it, and transmitting and transforming it into external work. It seems a very simple theory, but a revolutionary one, and yet very probable. Can we adduce any arguments in its favour? I think we can.

1. Urea, uric acid and urates are far more the exponent of the state of the nutrition than of work done. A man may part with these, and often does so, when he is doing no external work at all, when, for instance, he is lying in bed. 2. In sickness he gets rid of large quantities of these effete materials when he is doing no external work, and, indeed, cannot do it, mainly because before he was sick he overloaded his economy with nutritive material. Such experiments as Weston's walk showed that these excreta were not proportioned to the amount of work done. When the pedestrian fevered, these products vastly increased, but, of course, then he could hardly walk at all. 3. Although lifting weights bears some relation to the size of the body, intellectual, moral, spiritual, artistic, organising and governing work bears no predicable relation at all, either to the amount of food consumed or to the size of the body of the actor. 4. How does fasting so often elevate the bodily temperature and increase the strength, if we receive our external energy from the food? 5. Why do we go to bed when fatigued and not to the dining-room? How is it that we need sleep at all? Other reasons and arguments might be adduced, but I will spare your time and end with this one. Professor Bose has recently shown that the energy of dead things (so-called) and of living things, or vital energy, is the same. And he has shown some other very remarkable facts, as, for instance, that a metal wire may be poisoned more or less, so far as the power to let an electric current pass is concerned, by treating it with various agents which also act as poisons to living things. The energy is prevented from flowing into inorganic things by changes effected by such substances, and so the dead things cannot transmit, much less transform, such energy. So let us see to it that our constitutions are kept so clean, healthy and bright that the vital energy surrounding us shall have free access into the motors of our bodies, there to be transmitted and transformed into the best work of each according to our several capacities. I make no apology for bringing under your notice this further attempt on my part to harmonise the practical cure of this boy with high theory as to the meaning of tuberculosis, and the analogues of the animal machine to steam engines and motors, or its relations to the all-embracing law of the conservation of energy.

## Transactions of Societies.

### WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DECEMBER 2ND, 1904.

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

DR. A. E. RUSSELL read a paper on

#### DIAGNOSIS OF ACUTE ABDOMINAL DISEASES.

The first part of the paper dealt with methods of examination and their order of procedure, and great stress was laid upon the necessity of thorough examination of the thoracic viscera, the rectum and vagina. The general condition of the patient, with especial reference to the pulse, facial aspect and vomiting, was pointed out, as almost of equal importance as local abdominal signs. The author strongly deprecated giving opium in cases of doubtful diagnosis. The advisability of early operation in grave cases was insisted upon. Consideration of the relative frequency of the different varieties of acute abdominal disease, and of the age and sex of the patient, as illustrated by a large series of cases, was very helpful in forming an opinion based upon probabilities.

Mr. L. A. BIDWELL considered that there were two distinct questions raised in Dr. Russell's paper, *vis.*: (1) that of diagnosis of the lesion present, and (2) that of the necessity of immediate operation. He affirmed the existence of a rapid pulse and low temperature to be the gravest symptom in acute cases, and nearly always demanding immediate operation. He drew attention to the differential diagnosis between appendicitis and suppurative gall-bladder. In the former the rounded edge of the tumour is *above*, and there is an area of resonance between it and the liver, whereas in the latter, the rounded edge is *below*, and the dullness is continuous with that of the liver.

Mr. J. D. ARMOUR did not agree with Dr. Russell with regard to the question of the facies, and related three acute cases, none of which showed by their appearance the slightest sign of their condition.

Mr. E. P. PATON pointed out one feature not mentioned by Dr. Russell, which not infrequently occurs in acute cases. He referred to the *quiet period* following immediately after the acute onset, and warned practitioners not to be misled by this, as often the acute symptoms return in an aggravated form.

Dr. MANSELL MOULLIN expressed his surprise that so small a proportion of gynaecological cases occurred in abdominal surgery, and alluded to the frequency of acute abdominal trouble occurring in women of the child-bearing age, the most serious cases being those of hæmorrhage due to tubal rupture.

Mr. McADAM ECCLES was struck with the high percentage of cases of intussusception, *vis.*: 16 per cent., and thought it to be accidental for the years mentioned. He also alluded to a point not mentioned by Dr. Russell, *vis.*, hyperæsthesia. With reference to the question of the administration of morphia, Mr. Eccles advised *one* dose subcutaneously when the patient had to be removed, but if an operation is to be undertaken at the patient's own house without any removal, he strongly advocated that no morphia or opium be given. Mr. Eccles also mentioned that occasionally there were two or more causes of acute abdominal symptoms in the same patient.

Dr. SEYMOUR TAYLOR pointed out that indican is almost invariably present in the urine in acute abdominal cases, and considered it of use in deciding the diagnosis between injury to intestines and peritoneum or muscles. As to latent symptoms in cases of peritonitis, he submitted that the quiet pulse is the indication of the condition of shock, which is the first and most prominent condition of abdominal injuries, soon succeeded by rapid pulse and temperature. He considered pain to be by no means a necessary guide to threat of lesion.

Mr. ASLETT BALDWIN said that the cutaneous

hyperæsthesia mentioned by Mr. Eccles is of great interest, at the same time the symptom is very misleading. If present in a case of appendicitis, as an instance, and it passes off without amelioration of other symptoms, it is a sign of grave importance, and indicates immediate operation. With reference to the prominent symptom of shock mentioned by Dr. Seymour Taylor as being invariably present, Mr. Baldwin quoted cases of severe abdominal injuries where there was not the slightest sign of shock.

Dr. A. E. RUSSELL, in reply to Mr. Bidwell, commented upon the difficulty in the diagnosis of appendicitis and suppurative gall-bladder. In answer to Dr. Seymour Taylor, he said that pain commencing definitely in a region such as the iliac fossa or gall-bladder was probably indicative of the organ at fault, but fully agreed with Mr. Taylor that when the pain was referred vaguely to the umbilicus or general abdominal wall, it was valueless.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD DECEMBER 15TH, 1904.

DR. J. R. LOGAN, Vice-President, in the Chair.

DR. MIDDLEMASS HUNT showed a case of Primary Syphilitic Infection of the Nostril. The chancre was situated on the left side of the septal cartilage. The patient, a youth, æt. 17, had suffered from one-sided nasal obstruction and discharge for two months. There was considerable glandular enlargement on the affected side, and within the last fortnight a characteristic rash had appeared on the face and body. No history could be obtained as to the source or mode of infection.

Mr. DOUGLAS-CRAWFORD read a note on two cases of Actinomycosis. The first case was that of a ship's surgeon, the skin of the flank being the affected area. In the second case the patient was a butcher, and the sub-maxillary region the part affected. Excision was performed in both cases with satisfactory results.

Mr. K. W. MONSARRAT read a note on Constriction of the Ureter. After enumerating the different types of constriction, he related three cases illustrative of the condition. The first was a case of true stricture of the pelvic ureter which gave rise to symptoms mistaken for those of appendicitis; a cure was effected by dilatation of the ureter from the bladder. The second case was one of Hydronephrosis, in which the ureter was flattened against and bound by adhesions to the hydronephrotic sac; a plastic operation upon the ureter was successfully performed. In the third case there was Pyonephrosis with stricture of the ureter at its junction with the renal pelvis. Mr. Monsarrat suggested that in the etiology of similar cases of primary pyelitis of obscure origin, renal stasis caused by ureteral obstruction probably played an important part.

Mr. George Hamilton, Mr. Rushton Parker, Mr. R. A. Bickersteth, Dr. R. J. H. Buchanan, Mr. F. T. Paul, Dr. N. E. Roberts, Dr. W. Alexander, Dr. T. B. Grimsdale, Mr. G. P. Newbolt, Mr. Litler Jones, and Mr. Damer Harrison took part in the discussion.

Mr. RUSHTON PARKER read a note on  
PERINEAL PROSTATECTOMY.

He practised the operation as described by Dr. Parker Syms at the Manchester meeting of the British Medical Association in 1902. He had thus operated upon eight cases between December, 1902, and November, 1904. The ages of the patients varied from 59 to 76 years, five of them being over 70 years of age. The prostates removed varied in weight from  $\frac{3}{4}$  oz. to  $\frac{1}{2}$  oz. All the patients had been unable to pass urine without the use of a catheter before operation, and all had subsequently become enabled to hold and to pass water comfortably, except one case which terminated fatally. The after-treatment consisted in bladder drainage by means of a long tube for two to five days, and plugging of the prostatic gap for twenty-four hours with strips of gutta-percha tissue in preference to gauze. The gutta-percha strips can be removed

without disturbing the patient or causing hæmorrhage. A catheter is passed daily and the bladder washed out.

Dr. W. Alexander, Mr. Douglas-Crawford, and Mr. G. P. Newbolt took part in the discussion.

Mr. C. THURSTAN HOLLAND read a note based on a case of Central Round-celled Sarcoma of the Upper End of the Femur. The patient was under the care of Mr. G. P. Newbolt, at the Royal Southern Hospital. A series of radiographs was shown, illustrating various diseases of the bone bearing on the subject. The X-ray appearances of central round-celled sarcoma, myeloid sarcoma, periosteal sarcoma, abscess of bone, &c., were discussed. The fact that operations for malignant bone disease were so frequently followed by return of the growth was considered to be probably due to the condition being diagnosed too late. By the help of a good radiographic examination, suspicion might be cleared up very much earlier in the history of these cases, and thus enable better results to be obtained by means of operative treatment.

Mr. G. P. NEWBOLT described the clinical history of the case. He had performed amputation of the hip-joint, but the patient died the day following the operation.

Mr. R. A. Bickersteth, Mr. Rushton Parker, Dr. W. Alexander, and Mr. Damer Harrison took part in the discussion.

#### SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD DECEMBER 16TH, 1904.

DR. FREDERICK TAYLOR in the Chair.

DR. C. J. MACALISTER (Liverpool) opened a discussion on

SUDDEN AND UNEXPECTED DEATH IN CHILDREN, dealing mainly with a class of cases which appear to be due to toxic influences. He referred especially to the sudden deaths which take place in institutions devoted to the care and keeping of children. He quoted several cases in his own experience where children, sometimes with hardly any prodromal symptoms, in other cases with a few hours' suffering from headaches and diarrhoea or vomiting, had died in a cyanosed condition from asphyxia. At the *post-mortem* examinations sometimes a very localised patch of pulmonary consolidation had been found, at others a general congestion of the lungs, such as might be found in any case of suffocation, but no lesion of the nervous system had ever been discovered to account for these deaths, and he considered that they were probably due to a poison which exerted its influence upon the respiratory centre. In the institutions in which these deaths had occurred, it was found that collective bathing was frequently in vogue, and Dr. Macalister pointed out how saturated the water became with organic matter and micro-organisms after a number of children had been washed in it, and that in one school where this method of bathing was altered, about five years ago, these deaths had practically been stamped out, and the general health of the children had been vastly improved. Dr. Macalister quoted a case from the practice of Dr. Harris, of Birkenhead, of an appallingly sudden death in an infant, which had previously been healthy, and he felt disposed to ascribe this type of case (as suggested by Buzzard long ago) to infantile paralysis attacking the centre of the vagus, and suggested that in all probability the curious and selective poison which caused this disease might be discovered in some flaw in nursery hygiene. Other examples of toxæmia referred to were those in which hæmorrhage occurred from the stomach and cases of hæmorrhage into the suprarenal bodies, and a death from hæmorrhage from the carotid artery was also recited as having complicated scarlatina. In conclusion, it was pointed out that in some cases, which had been thought to be simple diarrhoea or some unimportant febrile

disturbance, had died suddenly and had proved to be examples of enteric fever; and he mentioned also examples of sudden death following diphtheria, in fulminating small-pox, and in gangrenous varicella.

Dr. J. PORTER PARKINSON, in considering the functional causes, referred to heart failure and sudden death in marasmus, to convulsions, usually causing death by asphyxia, to laryngismus stridulus as a rare cause, and to spasm of the glottis resulting fatally from pressure of an enlarged gland on the recurrent laryngeal nerve. The pathological changes in these conditions and in "over-laid" babies were described. Excessive emotion was a rare cause of sudden death in children.

Mr. J. THOMSON WALKER discussed the subject in relation to the thymus gland and the status lymphaticus. He summed up the clinical pictures of the latter constitutional state as (1) no previous evidence of illness; (2) previous restlessness, &c.; (3) thymic asthma. In many cases there is associated rickets. In others there is disease which might be sufficiently serious to end fatally without the addition of this peculiar lymphatic state. Possibly the condition might account for still-birth occasionally, and for deaths following violent emotion, sudden shock, and anæsthesia. Hypoplasia of the heart and coarctation of the aorta have been found in some of these cases, and sometimes an enlarged thyroid. Mr. Thomson Walker laid stress on the association of rickets, adenoid tissue in the naso-pharynx and laryngismus; also on the state of lymphatism as an important factor in producing a fatal issue in an otherwise simple illness. He discussed the pathology in reference to the pressure and toxic theories, an excess of thymic secretion or some other poison. Cases might be diagnosed from evidence of an enlarged thymus, if there were anything to suggest lymphatic hyperplasia.

Mr. A. H. TUBBY considered the surgical cause in reference to circulatory conditions such as hæmorrhage in the new-born, scurvy, ulcer of the stomach or duodenum, hæmorrhage during operation, and thrombosis; and to shock and the means of diminishing it. The shock following irrigation of the pleural cavity he ascribed to the nature of the fluid rather than to the actual irrigation, provided there were a free exit for the fluid. Among toxic conditions, he mentioned the absorption of iodoform and carbolic acid, toxins, and uræmia. Many other surgical causes connected with the throat and larynx, with mechanical effects from tying the hands of a restless child, with foreign bodies and pressure on the trachea, were also considered.

Dr. J. BLUMFELD referred to subjects in connection with anæsthetics, confining his remarks to those cases of sudden death in children during or after anæsthesia, in which the ailment had caused no loss of general health. The importance of a skilled anæsthetist for infants could not be over-estimated. Death in the pre-anæsthetic stage almost always occurred with absolute suddenness, and was due to too strong a vapour of chloroform.

Dr. PAGE drew attention to the occurrence of sudden death in the course of disease not necessarily fatal, such as phthisis. These cases were, he thought, due to an over-dose of toxin, an auto-intoxication, the patient having been living, as it were, on the edge of a precipice. He thought that one important result of the discussion would be to draw attention to the means necessary to prevent a sudden fatal issue in cases requiring surgical treatment, and from anæsthesia. In the toxic cases it was difficult to foresee a remedy.

Dr. YOUNG thought lymphatism more common than supposed in both children and adults, basing his conclusions on *post-mortem* examinations. Sudden death was frequent in exophthalmic goitre, especially after operations, and in myasthenia gravis, in which the thymus was persistent. Recently he had found the thymus persistent in several cases of sudden death.

Dr. EDMUND CAUTLEY insisted on the importance of the subject to the general practitioner, for most of these cases came under their notice, and they had

to make the autopsies and give evidence before the coroner. He detailed two such cases in which death had been ascribed to "mesenteric disease" and to typhoid fever. In neither were the history of the case, the appearance of the child shortly before death, or the *post-mortem* results sufficient to warrant these diagnoses, and he was inclined to ascribe the deaths to the status lymphaticus. In many deaths in the course of marasmus in infants, though the child was progressing favourably, it was impossible to assign an exact cause. Some died from syncope, others during a slight convulsion, and in many no cause could be found.

Dr. L. GUTHRIE remarked on congenital syphilis as a cause, and on the effects of too rapidly curing an extensive cutaneous eruption.

Mr. G. PERNET spoke in support of his views.

Mr. ARTHUR EDMUNDS thought that evil effects from sudden cure of eruptions were due to toxic absorption. He had seen similar results due to extensive skin grafting.

#### THE MEDICO-LEGAL SOCIETY. MEETING HELD DECEMBER 13TH, 1904.

SIR WILLIAM COLLINS, M.D., President, in the Chair.

Dr. HARVEY LITTLEJOHN exhibited four specimens of medico-legal interest.

Dr. R. R. RENTOUL read a paper on DEGENERATION: ITS CAUSES AND PREVENTION, with Reference to the Proposed Sterilisation of Certain Degenerates. The Census of 1901 revealed nearly half a million degenerates. The publicity of the certification of "the cause of death" prevented many inebriates being recorded in our national statistics; he would have the fact of death certified to the personal representatives of the deceased, the cause to the Registrar-General. From an exhaustive series of tables he exhibited, he concluded that the ratio of the mentally or physically unfit was 1 in 5 of the population, and the financial cost of their upkeep was not far from fifty million pounds annually. Immigration of undesirable aliens added to our unfits, emigration of our own healthy stock drained us of many of our fit. He would exact compulsory sterilisation (by vasectomy, salpingotomy, &c.) in the cases of idiots, the congenital deaf, confirmed epileptics, certain backward children, &c., and would allow voluntary sterilisation where there was obstetrical danger in a woman being pregnant and being delivered. In the compulsory class there should always be needed the sanction of the Commissioners in Lunacy.

After letters had been read from the Earl of Meath, M. Max Nordau, Mr. H. G. Wells, and Mr. T. J. Barnardo, F.R.C.S.E., an animated discussion was opened by the President.

Dr. JAMES SCOTT (Brixton Gaol) favoured segregation of the unfit, by an extension of the Idiots and Imbeciles Act (1886); Dr. Rentoul's proposal, if carried out, would add another burden to the life of the medical man.

Dr. H. B. DONKIN (Prison Commissioner) demanded a definition of "degenerate"; many prisoners were without this class.

Dr. T. B. HYSLOP (Bethlem Asylum) said degenerates increased with the progress of civilisation; among the unemployable unemployed the inhabitants of public institutions must be numbered. London was "a carbuncle on the neck of England," its areas of over-crowding were "acne spots" upon the body politic; treatment must be dietetic; the "food" imported should be supervised and unhealthy material should be expurgated. Dr. Rentoul, as others before him, had caught a "sperm-whale." England and Englishmen elected to "stand upon their heads," and necessarily experienced intellectual obfuscation—we must get right side up.

Sir JOHN McDUGALL, L.C.C., held it was the irregular and not the strenuous life—the Strand, not the East End—which filled the asylum; as a visitor

he often felt he was doing a social wrong in discharging the mentally insane when they were "recovered."

Dr. F. J. SMITH thought that at least it would be administratively practical to deal with those charged with homicidal or other personal violence; the public should not be told too much of the methods employed.

Mr. ARNOLD WHITE had advocated similar measures nearly two decades ago; lately, an hysteria had afflicted public opinion, its abnormal vibrations differed greatly from our pristine steady national character.

Mr. BERNARD SHAW regretted Dr. Rentoul had only had a medical, not a scientific, education! Medical men should instruct the public with authority, but their teaching was compromised by ignorance. We did not know what degeneracy nor heredity meant. If we got rid of the diseased we should lose many interesting people; epilepsy may be but a perverted form of energy. The terms used were relative to our social ideas; he could imagine an insane majority segregating a sane minority. Surgical and "chalk and opium" methods were applied too frequently by medical men to social problems. The population was the essential factor, and its quality was more vital than its quantity; we must breed from a good human stock even if the "sacredness" of marriage suffers.

Dr. C. R. DRYSDALE believed medical measures were not exhausted; the families of medical men were smaller than formerly.

Earl RUSSELL feared a good case had been overstated. Society interferes with Nature's weeding processes.

His Honour Judge RENTOUL faced this question practically day by day in his court; definition and differentiation were necessary.

Mr. GEORGE PERNET affirmed our ignorance of the nature of heredity.

Dr. HOWELL EVANS, with a large experience of London's invalid children, held that these weaklings were so either from accident or from heredity; treatment differed in each case; for the former ante-natal measures might do much.

Sir WILLIAM COLLINS, in summing up, deprecated loose talk where precise legislation was desirable. Weissman did not say the last word on heredity, as Watson's recent experiments on the transmission of acquired maternal immunity showed. The recent Commission on Physical Deterioration was more optimistic than the present discussion would indicate—"the inherited mean" must have been forgotten. Environment was regaining some of its temporarily discredited influence. The ethical aspect of the question had been ignored; what would be the state of society with numbers of sterilised criminal eunuchs roaming at large? He had little confidence in the short cuts of benevolent despots, and should hold up his hand against compulsory mutilation.

Dr. RENTOUL having replied briefly, the meeting terminated. Seven new members were enrolled.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, December 24th, 1904.

### TREATMENT OF FOREIGN BODIES IN THE EAR.

THESE are habitually divided into two classes—live bodies and inanimate bodies. The former consist generally of fleas, grasshoppers, or earwigs, which penetrate into the ear during sleep, while others are bred in the ear, from eggs deposited by flies, and these eggs produce worms or larvæ. Inanimate bodies are as variable as those found in the nose—pearls, boot buttons, pebbles, beans, grains of every kind, plugs of cotton wool, paper, &c. These may remain some time without causing any trouble, but generally they provoke buzzing, vertigo, nausea, vomiting, headache, and sometimes epileptiform convulsions. Symptoms that resemble cerebral disease (meningitis), and children have been treated for this affection.

If the foreign bodies are angular, pointed, infected, if they are capable of becoming swelled by humidity, if they are insects or their larvæ, they provoke violent inflammation with suppuration of the external meatus. The tympanum itself soon gets inflamed and otitis of the middle ear with all its complications sets in.

The treatment of these foreign bodies should always begin with repeated injections which, if persevered in, frequently succeed. If the body can be reached easily, a forceps or a crooked hairpin may be able to extract it. If, on the other hand, the symptoms are grave and threatening from penetration of the tympanum, the situation renders more radical means imperative. Either extraction should be made under chloroform or an attempt will be made to enter the middle ear and remove the obstruction.

### TREATMENT OF SCIATICA.

A simple yet effective method of relieving this painful affection will be found in the following:—

Nitrate of strychnine, 2 grs.;  
Water, 3½ oz.

A full Pravaz syringe injected daily in the region. Excellent results.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 24th, 1904.

At the Medical Society, Hr. Riese, related some observations on the

### SURGERY OF THE GALL-BLADDER.

He first spoke on the origin of calculi. Naunyn and his school had shown that stagnation of bile and infection of the biliary passages gave rise to gall-stones; Courvoisier had recognised this, as he looked upon gall-stones as a purely local disease. The view of Ewald that there must be a disposition to the disease was not of much importance. The infection generally proceeded from the intestines, but it might come to pass through a hæmatogenous channel. The speaker himself had seen cholelithiasis develop in connection with pneumonia. He related two cases of severe cholecystitis with strepto- and staphylococcus infection in which he was able to cultivate the cocci out of the bile obtained at the operations. In one case where the patients suffered from severe gonorrhœa, he assumed a gonococcus infection.

The colic did not come from active contraction of the bile-passages, as it came on even when the calculus was imbedded in a sac, but it arose from infection of the bile-passage, possibly, as Wilms assumed, from dragging on the peritoneal covering.

Jaundice also was generally the expression of an infection, as it often came on even when there was no hindrance to the flow of bile. That it came on when concretions blocked up the whole choledochus was, of course, understood.

As regarded indications for operation, in cases where there was no infection of the bile-passages one might wait in calmness if the gall-bladder was not swollen, or if the patient did not press for an operation. If there were changes in the gall-bladder it might be removed or one might content oneself with drainage. Hydrops of the gall-bladder called for operation only when it caused serious trouble. In chronic closure of the choledochus one must, of course, operate. Even in acute closure one might operate with confidence, no bleeding need be feared.

In very acute cholecystitis, in Körte's opinion operation should be performed at once, and here extirpation of the gall-bladder, even in the face of great difficulties, was to be preferred. In twenty-five such operations in which the speaker had repeatedly found abscesses in the walls of the gall-bladder, he had only lost three. He had also performed a successful operation in a case of acute diffuse cholangitis in which he had opened quite a series of abscesses in the wall of the gall-bladder, and had drained the bladder for a lengthened period.

When carcinoma of the gall-bladder was suspected

at least a preliminary laparotomy should be performed, when some operation perhaps only palliative, might be rendered possible.

He had performed 55 cystectomies and 30 cystotomies; he had performed a total of 104 operations on the bile-passages, with 16 deaths.

As to the question of recurrences, it must be borne in mind that when the case was one of turning aside an imminent danger, the choledochus could always be looked for. That calculi originated primarily in the liver was improbable; intra-hepatic stones only occurred when extra-hepatic processes had been at work.

Hr. Körte agreed with the speaker in all essential points. He almost always performed cystectomy, as recurrences unquestionably took place after simple cystotomy. Disposition undoubtedly played a part, for bile stasis and infection by themselves did not cause stones. The gall-bladder might, however, be full of pus and the choledochus closed without any stone being present. Whether ectomy of the gall-bladder was a certain preventive of recurrence was at present questionable.

In the acutest form of cholecystitis and in closure of the choledochus the indication for operation was a vital one. There first of all life had to be saved, whether recurrence was likely or not. In the simple form of cholelithiasis, however, we must not be too free with our indications, and must operate only when patients wished us to do so.

Hr. Israel mentioned the not infrequent occurrence of gall-stone and renal colic in the same patient, and then spoke in favour of a stone-forming disposition. The influence that drainage had in acute diffuse cholangitis was not explained. It could not be the flow of bile that induced recovery as the quantity of it was much too small.

Hr. Roth related two cases in which a year after cholecystotomy, fresh colic came on with peritonitis. The autopsy showed hepatic calculi in both cases. A stone had burst the cicatrix of the choledochus and had caused the peritonitis.

Hr. Mellin spoke on the

#### INJECTION OF THIOSINNAMIN IN CICATRICAL CONTRACTION.

He mentioned numerous cases, but could furnish no satisfactory explanation of the peculiar action of thiosinnamin injection. He showed a woman who had had a series of injections made on account of cicatricial contraction from burns on the arms and face. The preparation employed was a 10 per cent. solution with addition of glycerine. Considerable improvement was shown in the contractions.

Hr. Riere confirmed the observation and said that an ectropion of the eyelids had simply disappeared after the injection.

Hr. Mankiewicz had observed improvement in strictures of the urethra, but after a time the old condition returned.

Hr. Riere injected around the cicatricial mass and not into it. He had seen no development of ulcers.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, December 24th, 1904.

#### PREGNANCY AND UTERINE INVOLUTION.

The discussion of this interesting paper by Halban gave rise to an expression of diverse opinions on the function of pregnancy. Halban contended and gave evidence from examples that the monthly periods of the mother acted on the foetus *in utero* on and after the eighth lunar month of gestation. This, he concluded, was amply proved by the genitalia of the foetus being much larger at birth than what they are years after. All agreed that the breasts of the female and the prostate of the male were greater at this period.

Hofbauer was opposed to this theory of Halban, and said that he had had the opportunity of examining the mucous membrane of the uterus in twelve cases, and

only found one where changes had taken place, although ripe follicles in the ovaries were discharging ova. The size of the uterus was due, according to his opinion, to the addition of fibrous tissue and not muscular tissue, as was generally supposed. This may be the result of oedema or its proximity to the bladder. It is too early to conclude that the poison generated in the placenta is the morbid cause of eclampsia.

Fellner was of opinion that the ovaries were as active during pregnancy as before it, as we find follicles in every stage of their life history, even to bursting and leaving the ovaries, while the menstruation wave can be traced along the mucous membrane, leaving nothing but the menstrual discharge to complete the phenomenon. It is quite possible that the material from the ovaries passes on to the foetus and produces in it the phenomena described by Halban.

Tandler remarked that the watery production of the embryonal tissues was generally well known without attributing all this fluid accumulation to the placenta alone.

Mandl thought that this idea of enlarged uterus in the new born was not new, but had its origin in Baier, of Strasburg, who pointed out long ago that the uterus of the foetus *in utero* resembled one at puberty more than it did at any intervening period when involution really occurred. Under any circumstances investigations in this direction must be accepted with great reserve, as the cases must be few where actual demonstration can be accurately carried out. The menstrual changes in the mucous membrane was supported by an ovarian activity, but when we meet with parturition going its usual course after the ovaries have been removed, and the menstrual changes still present, we ought to pause and await more accurate knowledge. But these theorists are not satisfied with the ovarian secretions being the only cause; they tell us in the next breath that that phenomenon is caused by the secretion from the placenta. The hypotheses start out with the assumption that the ovarian secretion first stimulates the placenta to secrete.

Zappert thought that oedema during pregnancy was one of the peculiarities of gestation, and particularly in the surface of the foetus, which showed signs akin to this after-birth in parts of the skin, scrotum, symphyses, and inner surfaces of the thighs.

Halban, in replying, said the menstrual changes in the uterus could not be affected by ovulation, as careful section of the ovaries could not discover any follicles. It might also be noted here that in elderly children, though ripe follicles are present in the ovaries, no change can be observed in the uterus. These facts still add to our difficulty of demonstrating a close alliance between ovaries and uterus. If this be taken along with the fact that castration of a female during pregnancy in no way interferes with the course of gestation, it must be admitted that the ovaries have no influence over the foetus during pregnancy, and those genital changes so frequently observed in the foetus must be due to placental stimuli, as pointed out by many independent investigators.

#### URTICARIA XANTHELASMOIDEA.

Nobl showed a child, *æt.* 2½, covered with an exanthematous eruption varying in size from a millet seed to the size of a groat. The only parts escaping were the face, palms of the hands, the hairy scalp, and the soles of the feet. This rash had yellow tops, fading in the base to a coffee colour, each swelling having a peculiar soft, pliable feeling as if it were loose substance. The finger nails were irregularly formed and raised, having a brown pigmentary appearance outlined with a white ring merging into the surrounding normal tissue. This case deviated from former descriptions in so much that all former histories tell us that these tubercles are usually disseminated in groups over the body or in circinate plaques, while Nobl's case is universal. The disease seems to have commenced acutely about the fourth month of life. The first place of appearance was the trunk, whence it radiated over the limbs, &c. No burning or itching.

nor excoriation appear to have been present at any time in its history, therefore no general disturbance, rhachitis, or other changes were noted.

Tilbury first described this disease in 1875 as xanthelasma, from its clinical appearance, although he found it in many cases associated with urticaria, and presumed that the efflorescence might be due to some irritant of the vaso motor centres. It commences usually a few days after birth, and continues, in spite of every remedy yet tried, for twenty or thirty years.

Unna examined the morbid growths histologically in 1887, and found the brown coloration to be a deposit of fine granular melanotic pigment in the basal rete mucosa, and subepithelium of the cutis. The elevations, tubercles, and plaques were caused by oedematous swelling in the papillary bodies, but more particularly owing to the aggregation of Ehrlich's giant-cells in the papillæ. It has now been conclusively proved that these giant-cells are pathognomonic of the morbid process which is now presumed to depend on an angio-neurotic condition.

Ehrmann thought the presumption of irritation clinically failed in this case, as no irritation seems to have been present at any time of its history. He did not scruple to accept an angio-neurosis, but to his mind the symptoms did not justify an irritative origin. The giant-cells might be the product of some toxic influence and probably the real cause of the disease.

#### CHRONIC ENTERO-STENOSIS.

Ewald brought forward a child on whom he had operated for cicatricial stricture in the lower part of the jejunum. The central cicatrix was the result of tubercle. Above the stenosis there was great dilatation but very little hypertrophy, while below the bowel was empty and contracted. In the region of the ileo-cæcal valve a second stricture was present, which was resected also. The physical conditions were similar to the above, *i.e.*, above the stricture great dilatation was present, but no hypertrophy, which is usually present above obstructions. From these facts he attempted to evolve the principle that when we meet with an obstruction with dilation above and no hypertrophy, diligent search should be made for other obstructions in the bowel as in the case presented.

### Dungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, December 24th, 1904.

#### HEART SYPHILIS.

In the current number of the *Gyógyászlat*, two cases of heart syphilis are described by Hartge:

CASE I.—A clerk, æt. 48, had suffered for several years from cardiac pain radiating down the arm, when he suddenly became unconscious and was apparently moribund. He was revived with stimulants, but suffered from attacks of excruciating pain for weeks, for which morphine injections were required. The cardiac physical signs were normal; the pulse was intermittent, but varied in frequency. As there was a history of a penile sore for which he had taken calomel internally thirty years previously, and of his wife having had several abortions, but no full-term children, he was treated with inunctions of blue ointment and iodides internally. Improvement was slow, but a year later he could resume his business, the pain had ceased, and the pulse scarcely varied in frequency; arterio-sclerosis could be excluded as there were no signs of it and the improvement was permanent.

CASE II.—A merchant, æt. 42, had syphilis at 22, for which he was most carefully treated. Ten years later he had cardiac pain radiating down the left arm, which, as there were no physical signs, was attributed to hypochondriasis. The patient, however, applied anti-syphilitic remedies and was cured. On two subsequent occasions this history was repeated. On the last occasion the symptoms, which consisted of a feeling of oppression, insomnia, constipation, and anginal attacks, for which morphine was required, did

not disappear till some months after a course of mercury and iodides. The patient is now quite well.

#### URTICARIA FROM ODOURS.

An unusual case which has defied treatment may here be recorded: A man, æt. 26, of a naturally intemperate and nervous temperament, presented himself at the clinic. Eleven years previously he had had adenoids in the naso-pharynx, which were cured by operation. He never could endure the perfume of eau de Cologne, musk, patchouli, and other toilet scents, and could not enter a barber's shop, as these odours always produced severe migraine. He became a liqueur manufacturer, and remained one day for two or three hours in the "laboratory." Headache, giddiness, and syncope ensued. On being removed he sneezed violently and was troubled with abundant nasal discharge. His face then swelled and the whole body was covered with an urticarial eruption accompanied by burning sensations and great itching. Similar symptoms followed other attempts to remain in the laboratory and appeared to be always provoked by the perfumes of aniseed, peppermint, fennel, coriander, and other aromatic substances. Examination of the nose showed nothing abnormal, except slight swelling over the right inferior turbinated bone. There was no hyperæsthesia. All treatment proved futile.

Dr. Hülth Hümér related cases of

#### SYPHILIS OF THE THYROID GLAND.

The cases fell into two groups:—

GROUP I.—Acute syphilis with enlargement of the thyroid (thyroiditis parenchymatosa syphilitica). There is a diffuse enlargement of the gland, due to acute parenchymatous inflammation such as occurs in the liver, spleen, &c.

GROUP II.—This group is found in congenital and tertiary syphilis. There are two varieties sharply distinguished from each other.

(a) Thyroiditis interstitialis syphilitica. Only two cases are on record. In one the syphilis caused myxœdema, which rapidly disappeared under anti-specific treatment. In the second a tumour, the size of the fist, was thought to be malignant. Complete excision was impossible. Microscopic examination revealed its benign character. The patient had acquired syphilis many years previously. Under treatment with potassium iodide, the tumour completely disappeared in three weeks.

(b) Gumma glandulæ thyroideæ. Several cases have been observed in children, the subjects of hereditary syphilis. The writer records a case of acquired syphilis. A man, æt. 58, had carcinoma of the larynx and benign tumour of the thyroid. Tracheotomy was performed on account of dyspnoea and cyanosis. To reach the trachea, the enlarged thyroid was divided with Paquelin's cautery. There was much hæmorrhage, and the patient developed acute bronchitis. After three months' treatment with potassium iodide, the enlargement entirely disappeared.

### The Operating Theatres.

#### NORTH-WEST LONDON HOSPITAL.

OPERATION FOR CHRONIC NASAL CATARRH OF ELEVEN YEARS' STANDING.—MR. MAYO COLLIER operated on a boy, æt. 15½, the subject of chronic nasal catarrh with snuffing and mouth-breathing for the last eleven years. The mother, who accompanied the boy to the hospital, stated that as long as she could remember her son had perpetual cold in the head, running from the nose, and cough, more especially at night and in the morning. In fine and dry weather, for a few weeks at a time, he was more or less free from cold in the head, but on the slightest provocation his nose became almost completely stopped up, necessitating the frequent use of a handkerchief. The boy complained of headaches and disinclination to follow his studies or to indulge in the ordinary games that most boys are pleased with. Mr.



Collier pointed out that at his first examination he was surprised to find, with a history such as had been related, that the arch of the teeth and the position of the palate were scarcely at all affected; as a matter of fact, the maxillary arch was particularly well formed and the teeth well shaped and well grown, and in perfect symmetry. The arch of the palate was an example of what an arch should be, and the whole of the upper jaw was well developed, and in keeping with the rest of the face. One would have expected, he said, that with a history of nasal obstruction for eleven years the maxillary arch would have been disarranged and the palate high and V-shaped. The more or less continuous nasal obstruction could only, he thought, have been of recent date, otherwise the palate and the whole upper jaw must have suffered severely. Mr. Collier further remarked that the state of the nose and of the posterior nasal space was typical of the condition of chronic nasal catarrh. The mucous membrane of the whole nasal cavity was hypertrophic and congested, and the lower turbinal bodies on both side were completely occluding the lower meatus. There was little doubt, he said, that the post-nasal space was full of adenoid vegetations, which would be easily inferred from the elevations present on the oro-pharynx. He proposed not only to remove the vegetations on the oro-pharynx, but also to take away the whole of the redundant tissue hanging from the lower border of the lower turbinal bodies. The patient having been anaesthetised with chloroform, Mr. Collier introduced a long straight pair of serrated forceps in each lower meatus, and with the assistance of his left index finger in the post-nasal space he engaged the whole of the redundant tissue in the grasp of the forceps; these, then, being securely locked, a few twists to the right and left were sufficient to remove the tissue in question. Very little bleeding followed this manoeuvre. The same operation was next repeated on the other side. The oro-pharynx was found to be full of adenoid vegetations, and these were removed with a curette. A good deal of hæmorrhage followed the removal of the adenoid vegetations, but the pressure of a sponge in the posterior space soon controlled it. The improved nasal respiration was very apparent during the bleeding from the posterior nasal space, blood and air passing through the nasal chambers with great ease. Mr. Collier said that any other treatment but the one adopted was, in his mind, quite futile in dealing with such cases.

**OPERATION FOR RECURRENT POLYPI.**—The same surgeon operated on a woman, æt. 45, who four years ago had presented herself with severe asthma and nasal obstruction. He, on that occasion, removed twenty-nine polypi with the effect that the asthma had completely subsided, and had not even returned with the recurrence of the polypi. Mr. Collier demonstrated some particularly large polypi invading the vestibule on each side. With the assistance of 20 per cent. solution of cocaine and adrenalin, nine of these were removed so as to restore respiration on each side. He pointed out that in these cases it was not advisable to prolong the sitting indefinitely as the removal of the lower polypi made room for others which would be visible at a subsequent examination. It was remarkable, he thought, in this case that, although the polyp had returned, the asthma had not. The most the patient complained of was a troublesome cough at night time and in the morning.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 28, 1904.

**UNAVOIDABLE MISHAPS FOLLOWING OPERATION.**

THE immense impetus that the discoveries of general anaesthetics and antiseptic methods have given to surgical operations has doubtless enlarged the scope of the benefits derivable from medical science to a degree undreamt of by practitioners of the early part of last century, and without attempting to minimise the good that has accrued to humanity at large by early and more extensive operations, it is well to bear in mind that there are still certain *opprobria medicinarum*, or, more strictly, *opprobria chirurgiarum*, which have yet to be removed. So little risk now attends operations conducted *secundum artem*, that the surgeon, in a case presenting difficulty in diagnosis, does not hesitate to open the abdomen or cut down on a tumour, in order to solve the problem by direct inspection. Compound fractures, once the most dreaded class of injuries, are now regarded so light-heartedly that simple fractures, such as those of the patella and olecranon, are exposed and wired without anxiety, and almost every week fresh surgical procedures are planned and carried out for the relief of symptoms that are merely uncomfortable, and detract but little from the enjoyment of life. At the same time the light-heartedness with which the surgeon takes his scalpel in hand occasionally receives a rude shock, not so much from any want of skill or prescience on his part, as from the occurrence of some unlooked-for eventuality which he is at a loss to explain even when it has happened. Some of these regrettable calamities were dealt with by Richardson, of Boston, in a recent paper read before the American Surgical Association, and what is true of his country, where operative surgery has attained such a high degree of evolution, is unfortunately no less true of the same art in the British Isles. In the first place, he asks very pertinently, can septic

infection always be avoided? Theoretically, of course, it should be, but even in the modern temple of asepsis, which no hospital is content to be without, infection of deliberate wounds does occur, and though the surgeon very justly regards such an event as a reproach on his *technique*, it may be taken for granted that while man remains fallible, breakdowns of this character will continue to happen. Even though the conditions of operation be approximated as closely as possible to those of a bacteriological experiment, there are certain factors that cannot always be eliminated, and, granted that it is possible, and it is always possible by aerial contamination for germs to reach a wound, the injury to parts entailed by the operation, and the impaired vitality of the tissues from cachexia or ill-health, will at times determine a suppuration which will cause unpleasant surprise when the dressings are removed. As with suppuration, so with hæmorrhage. Modern instruments and resources are theoretically as capable of abolishing risk from hæmorrhage as asepticism is that from infection, but without reckoning these instances in which oversight or technical difficulties have allowed a vessel to pass unsecured, there is a proportion of cases in which as far as our present knowledge goes, post-operative hæmorrhage may be said to be inevitable. Richardson instances the tendency to hæmorrhage exhibited by jaundiced persons who come under operation for the relief of obstruction to the gall-ducts; three such cases he has had in which, the patient died from uncontrollable capillary hæmorrhage, besides one similar death in a case where at the time the operation was undertaken a biliary fistula existed, and there was no jaundice. Richardson always tries for some time before undertaking an operation on jaundiced patients to promote the coagulability of the blood by giving ox-gall, fruit-acids, and calcium chloride, but he has not found these means always efficacious, and he consequently writes down a certain number of deaths from hæmorrhage after gall-bladder operations as unavoidable. Then, too, with regard to the fortunately rare cases in which hysterectomy is followed by complete suppression of urine, there seems to be a proportion of instances in which no amount of foresight or care can obviate this risk. When the kidneys are diseased, the surgeon should take care to ascertain the fact before operating, as death in such cases is to be apprehended, or, at least, feared, but even when the kidneys are demonstrably healthy hysterectomy sometimes is followed by suppression of urine, and no adequate explanation is forthcoming *post-mortem*. But the most common cause of unavoidable death after operation, and the one that causes both surgeon and relatives the greatest shock, is pulmonary embolism, and this occurs always almost without preliminary signs of phlebitis. It is principally after extensive dissections in the female pelvis that phlebitis occurs, and then generally in the veins of the left lower limb. Unpleasant and irksome as this complication is,

happily it generally subsides without giving rise to untoward symptoms—that is, if the phlebitis is not septic. Richardson, in five thousand abdominal operations, has never seen a simple phlebitis with thrombosis give rise to a pulmonary embolism, but, on the other hand, he has had the chagrin, shared by other surgeons, of seeing a patient making a typically good recovery from a severe operation on the uterus or the appendages suddenly carried off by pulmonary embolism. Rare though these unavoidable cases of death after operation are, they have to be seriously weighed against the advantages likely to accrue before undertaking or advising any surgical procedure on a patient.

#### NUMBERING THE PEOPLE.

THE burden of the white man becomes a very real factor in life when we consider our imperial responsibilities. Our Empire covers some twelve millions of square miles, just one-fifth of the surface of the earth; and the forty-one and a half million people in the United Kingdom, with some few million white men in Canada, Australia and South Africa, are morally responsible for the well-being of over three hundred and thirty millions of coloured folk. The responsibility rests heavily upon the authorities, more especially those who are concerned in the matter of safeguarding public health and local administration. The Census of 1901 has revealed very many curious facts, and these have been made available for consideration and comparison by the recently published General Report of the Commissioners. It would appear that in England and Wales there were 36,444 men and 10,426 women employed in municipal, parish and other local or county administration. This shows a very considerable progressive increase, for in 1881 there were rather less than 18,000 men, and only a little over 3,000 women so employed. By 1891 these numbers had risen to 19,700 men and a little over 5,100 women. To this enumeration we must add 2,174 men and 6 women engaged upon the making and upkeep of roadways, as well as 50,300 men paviors and one woman. This last item shows a remarkable progress, for in 1881 there were only 15,097 men so engaged. In drainage and sanitary service there were 7,189 men and 1 woman, which compares only with 1,363 men in 1881. As scavengers and crossing-sweepers we find 8,478 men and 110 women, comparing with 2,694 men and 174 women in 1881. This is a goodly army engaged in the noble work of good government and sanitary improvement. It is well to know that in spite of the outcry of reactionaries the number in these services are still increasing, and by comparison this is notably the case as regards women. There is a laudable tendency to appoint more lady sanitary inspectors, and, considering the overcrowded condition of the slums, this is a very necessary provision. The Census returns confirm the statements of the Registrar-General as regards the prolongation of

life and the fall in the birth-rate; but this latter defect is righting itself, at all events so far as regards England and Wales, though Scotland, and especially Ireland, still lag behind. The disquieting fact of the increase in the number of mentally deficient is somewhat discounted when we realise that at all events part of this increase is due to difference of classification, and more particularly to the text of the wording of the Census schedules. Formerly, heads of families were requested to give returns of "lunatics" and "idiots." In 1901 this was softened to "mentally deficient," and there can be little room for doubt that this suavity of the words produced a nearer approach to the truth. Still, the fact remains that at the last Census 4,393 persons in England and Wales, 4,078 in Scotland, and 5,618 in Ireland for every million were mentally affected. This compares with 3,552 in England and Wales, 3,358 in Scotland, and 4,504 in Ireland at the Census of 1891. It is also notable that patients in asylums have vastly increased. Turning to another aspect of the population, we find that there was a large decrease in the number of blind. The fall being from 838 persons to 792 persons per million inhabitants. We may, as sanitarians, take credit for a large share in this decrease, for undoubtedly, cleanliness is one of the great preservatives against this calamity. There was also a decrease in the number of deaf and dumb, which may, although in a lesser degree, be attributed to improved health conditions. There is a lamentable state of affairs revealed as regards poverty. At the taking of the Census it was found that one in every 131 males, and one in every 190 females, were living in workhouses or infirmaries. This shows a general increase over 1891 of 5.5 per cent. The greater number of men is partly accounted for by the fact that husbands and sons, when dangerously ill, must, almost perforce, go into the infirmaries, but women, for various reasons, are more often nursed at home. It was found that the greater number of men were classed as general labourers; they formed rather more than one-fifth of the total male population. As regards women, the most numerous class were domestic servants, who composed nearly one-fifth of the female workhouse population. Turning to yet another aspect of the returns, we find in some of the industrial centres an increase in the employment of very young boys, and a decrease in the employment of men above middle age; it would seem almost as if we had here some explanation of the growing pauperisation. A more pleasing fact is that, while there is an increase in the percentage of young women workers, there is a slight decrease in those employed about marriageable ages. This is a step in the right direction. We must leave for a future occasion the consideration of that most difficult of problems, the concentration of the population.

#### CONSUMPTIVES IN HOSPITALS.

THE question is rapidly coming to the front whether it is fair to the inmates of general hospitals

to expose them to possible tuberculous infection by allowing patients suffering from pulmonary tuberculosis to occupy the same wards as those suffering from other diseases. The fact that rooms, clothing, &c., can be, and are, rendered infective by prolonged contact with consumptives no longer needs demonstration, and already many municipal authorities have taken steps to secure the adequate disinfection of such premises, the destruction of clothing, &c. If it be admittedly dangerous for the healthy to inhabit rooms in common with the phthisical, how much more dangerous must it be for the sick in hospital? Their suffering bodies are obviously in a state of morbid receptivity, or, in other words, of diminished resistance, and it is impossible to deny that the presence of, it may be, a large proportion of tuberculous patients in the wards must create a very real danger for them. That the risk should hitherto have escaped practical recognition is due, no doubt, to the fact that the consequence does not follow so closely on the cause as to strike the attention, but in the light of our present knowledge the reality of the danger cannot much longer be ignored. If this argument should hold good for the inmates of general hospitals, how much more cogent is it in respect of hospitals which receive consumptive patients exclusively? There the infection is intensified, and they turn, so to speak, in a vicious circle. We refer, of course, to "closed" hospitals, for if certain precautions are enforced, the open-air sanatoria do not participate in this reproach. It is hardly to our credit that the initiative in the direction of the segregation, or shall we say the isolation of patients afflicted with pulmonary tuberculosis should have come from France. Yet such is the case, for we read that the Extra-Parliamentary Commission appointed some time since to consider how best to circumscribe the ravages of this disease, has rendered a report on the strength of which the Minister has drawn up a circular to be sent to all hospitals and similar institutions throughout the country, urging the desirability of taking immediate steps for separating tuberculous from non-tuberculous patients. The wisdom of such a course is so obvious as to dispense with the necessity for arguments to support it. We are aware that many diseases constitute a "soil of predilection" for infection by the tubercle bacillus, and we may go a step further and assert that every debilitating disease—and which of them is not debilitating?—creates a passing liability to tuberculous infection. Chronic malnutrition, however induced, as in diabetes, rheumatism, &c., materially reduces the vital resistance of the tissues, especially to tuberculosis. Yet we continue to permit a morbid promiscuity not so far removed from that of the days when three or four different patients were huddled into one hospital bed. We have separated the beds, but we have only reduced the evil in degree and not in kind. In years to come our successors will doubtless look with as much amazement on our present hospital promis-

cuity as we do on that of our predecessors. The erection of sanatoria is one step in the specialisation of hospitals from this point of view, but as the accommodation is unlikely, for many years to come, to suffice for more than an infinitesimal fraction of the tuberculous, it behoves us to provide provisional protection to the tuberculous sick unable to avail themselves of the advantages of the sanatorium. When we consider that in France 45 per cent. of the in-patients are tuberculous, it is evident that the problem is of some magnitude. One solution of the problem in town where there are several hospitals would be to allocate one or more of the buildings exclusively for this purpose. But patients evince the greatest objection to remain in such special institutions, preferring the general wards; moreover, the physicians attached to the particular hospital would probably object to the monotony of ministering exclusively to the phthisical. On the whole, the best plan for the present would seem to be to place apart certain wards in all hospitals for the reception of the tuberculous pending arrangements for relegating them to cheap buildings in the open air, far away from towns—a disposition which has the advantage of being as beneficial for the sufferers as it is hygienically desirable.

### Notes on Current Topics.

#### Toilette Eye Drops.

ANYTHING which is supposed to add to feminine charms is laid under contribution in these days, quite regardless of the consequences and risks. Perhaps one of the most reprehensible and dangerous practices in connection therewith is that which makes the delicate organ, the human eye, the medium for gratifying vanity. The following characteristic paragraph appeared in a recent number of a woman's magazine:—"A perfectly safe and successful way to secure the beauty of eyes that sparkle is to put a drop of '——' eye drops (price 5s. 6d. a bottle) into each eye before going to a dinner, a dance, or any other function, and then to take the bottle with one, and to put a drop with the finger-tip into each corner of both eyes when in the cloak-room. This will keep them bright the whole evening." We can only describe the advice here given as in the highest degree worthy of unqualified condemnation. To tamper with the eyes by applying to them drugs which are supposed to make these delicate organs sparkling and bright is, we imagine, a practice which would hardly appeal to persons of ordinary common sense. And yet it is grievous to have to admit that there are persons who, for the time being, cease to act sanely in order to pander to the demands of vanity. Vanity, as we know, stops at nothing; among some women it becomes a fetish, which dominates their whole being, and leads them into paths of foolishness and wrongdoing, escape from which is generally impossible without the payment of penalties—more or less severe. So far, however, as the promiscuous application of powerful drugs in the form of drops to

the eyes are concerned, every medical man knows that such a practice is fraught with the gravest risk to these organs, and the public should take warning that harm may result which cannot afterwards be rectified.

#### Influenza Rampant.

THE war clouds in the Far East are having a faint but distinctly undesirable reflex in the Far West in the shape of a widespread epidemic of influenza. It may be doubted whether the malady has ever been marked with a more rampant aggressiveness than that displayed during the past five or six weeks. Fortunately the type of the disease is mild, and many persons may be seen following their daily occupation with the dullness of this most depressing disease writ large upon their features. Needless to say, any patient who goes about his ordinary business while suffering from influenza is running a great and, it may be, fatal risk. Rest in bed, a dose of quinine, nutritious food and free stimulation are the best remedies, as all practitioners and most laymen have by this time learnt to recognise. For all the comparative mildness of the present type, influenza is, nevertheless, answerable for a great number of deaths in the United Kingdom. When the long-continued wave of infection shall have once again receded from our shores, it will be found that the total mortality has been little short of that experienced in a great national war. For all that, medical science may rest serenely happy in the firm persuasion that one day this preventable disease will be prevented. The influenza bacillus is doomed to share the fate of the mammoth and the dodo and other extinct animals.

#### A Novel Test for Sobriety.

MEDICAL men generally, and police surgeons in particular, are frequently called upon to give an opinion on the sobriety of an individual, and they know well that there is nothing a clever counsel can make more fun of, or discredit more easily, than evidence as to drunkenness. Unless a man was in an advanced stage of alcoholic poisoning, it is always possible for him to plead afterwards that he was ill, or mentally distracted, or under the influence of some other drug than alcohol, and—although the doctor may be perfectly certain in his own mind that drink was the cause of the trouble, it is very difficult to make the evidence sound convincing to an unsympathetic court. He may have applied the time-worn tests of "British constitution" and "mixed biscuits" and satisfied himself that the failure of the prisoner to tackle these "tongue-twisters" was the result of incoordination of the vocal muscles, but a lenient bench do not always find these tests conclusive. A novel and interesting experiment was introduced by Dr. Rigby into the examination of an accused man at Chorley the other day. Dr. Rigby had run through the gamut of ordeals for drunkenness without arriving at a result satisfactory to his own mind, although the prisoner was able to carry a full glass of water across the room and back

without spilling more than a few drops at the turn. The policeman was sure the man was drunk from "the gleam in his eye," so Dr. Rigby evolved a final and extempore test by making the accused read a copy of the Education Act. He accomplished this task with such a command of phrase, and such a degree of scholarship, that the magistrates' hearts melted when they heard of it, and they accepted the prisoner's view of his own case. The Education Act has been the cause of much vituperation and has had many unkind things said about it, but if it can ward off convictions for drunkenness it is likely to be cherished in a good many homes.

#### The Conferring of Honorary Degrees on Sir F. Treves and Major Ronald Ross.

THE Senate of Dublin University, at its last meeting conferred the honorary degrees of Master of Surgery and Doctor of Medicine on Sir Frederick Treves, C.B., Surgeon-in-Ordinary to the King, and of Doctor in Science on Major Ronald Ross. The Public Orator was most happy in the Latin speeches in which he introduced the recipients of the degrees. "To Sir Frederick Treves principally, as Serjeant Surgeon-in-Ordinary to the King, is attendance on his Majesty entrusted, as, of old, attendance on the Emperor Augustus was assigned to Antonius Musa. You all remember the gratitude and uplifting of heart with which not only we, the subjects of his Most Gracious Majesty, but almost the whole world, rejoiced at the happy result of this eminent surgeon's skill, when the head and main pillar of the State was endangered, and it was uncertain whether that august brow was to wear the covering of death or the royal crown. Formerly, too, in the South African war, this great surgeon had shown with marked success his beneficent and salutary skill." The reference to Major Ross was no less happy, and ran as follows:—"The serious mortality caused by those minute yet deadly parasites, called plasmodia by scientific men, is well known; nor can any more righteous war be waged than that against those microscopic Hydras which germinate in their myriads throughout our frame. In this war a most brilliant victory has been gained by Ronald Ross, a man of the most varied and striking gifts. Formerly a distinguished major in the Indian Medical Service, he has also won success as a profound mathematician, an admirable novelist, a dramatist of no mean order, and now is one of the most eminent of Professors in Tropical Medicine. It has been supposed that malaria arose, as Lucretius says:—

When soaked with drenching rains the wide  
earth streams,  
Corruption breeding 'neath the sun's fierce  
beams.

But, entering on a new and unerring path of investigation, this great man has shown with brilliancy and certainty that the seeds of that disease are carried broadcast by mosquitoes, so that in numberless cases whomsoever those noxious creatures bite, they not merely bite, but infect with

poison. And so it has come to pass that by his aid we can clearly learn in what way to avoid this most grievous malady." The University is to be congratulated on the choice of the two eminent members of the medical profession whom it has selected for honour.

#### "Harvey Lewis," Memorial Hospital.

ACCORDING to our lay contemporaries, the sum of £80,000 has been recently left by a charitable devisor for the ultimate purpose of founding another hospital in Dublin. While we quite recognise that such a munificent bequest for charitable purposes is worthy of the highest praise, we are compelled to express our regret that the devisor was not better advised. We believe that our readers will agree that while one of the chief needs of Dublin in the direction of charity is the provision of greater funds for the existing hospitals, the last thing required is the creation of a new hospital. To put the present state of affairs concisely, buildings are plentiful, but annual income is small. If in the present case this magnificent sum had been apportioned between the large Dublin hospitals, the benefit would have been incalculable. As it is at present apportioned, it merely means that an insufficient sum will be spent in unnecessary bricks and mortar, and that another hospital will be created to vie with those at present existing in appeals to the charitable.

#### The Sugaring of Wine.

ALL that glitters is not gold, and not all so-called wines are the fermented juice of the crushed grape. It is easy and economical to manufacture a palatable liquid from dried raisins which, in skilled hands, closely approximates real wine in appearance and taste. During the last few years however, the production of wine, particularly in Algeria, has been so abundant that it has hardly been worth while to employ the comparatively expensive raisins, but wine-growers in France are up in arms against another form of sophistication which interests us as consumers. This consists in the employment of sugar, either to reinforce wines that are deficient in alcoholic strength, or for the purpose of "making" wine by pouring water on the residues after the expression of the true wine; this, duly fortified with sugar, is allowed to ferment, and so the unscrupulous grower gets a second drop, so to speak. From the point of view of health, the practice is probably attended by little risk in spite of the specious arguments advanced by those who desire to see it put a stop to. But it is none the less a distinct fraud on the public, and what is more to the point, the revenue in France is thereby defrauded of its due, since the additional alcohol thus added to the wine escapes taxation. Wine is so plentiful in many parts that it is sold at three halfpence a quart, and the market is glutted even at this price. One can understand, therefore, that wine-growers resent unscrupulous dealers being allowed to enhance the existing

stagnation by artificial means, and as they are an influential body we are justified in hoping that all the wine imported to England will, in the near future, be the unsophisticated juice of the grape.

#### Medical Report on the Boer War.

THE quality which is designated in parliamentary circles "indecent haste" certainly has not characterised the publication of the medical report on the South African war, for it only put in an appearance last week, and even now it is far from complete. The task of preparing it has truly been a herculean one, and it cannot be said that Surgeon-General Sir William Wilson and his staff have shirked their work. Still it is not unreasonable to suppose that with a little organisation and equipment the report might have been issued some considerable time back, and we suppose that the fixed military principle of cutting the Medical Department down to the severest limits lies at the root of the long-drawn-out delay. Coming as it does years after popular interest in the events of the war and the popular indignation at the breakdown of the medical arrangements have subsided, we fear that it will do little to clear the *personnel* of the medical staff from the blame so freely attached to them at the time; but if people will take the trouble to read the report now that it is published, they will find that, whoever was to blame, it was not the Director-General and his colleagues. Medical men who are acquainted with the scandalous shortage of officers in the Royal Army Medical Corps long before the war broke out had over and over again predicted a catastrophe when the strain of active service was experienced, and it is only fair to say that the predictions were nullified solely by the unceasing devotion to duty of the army doctors themselves. But although an actual catastrophe was avoided, a very serious breakdown occurred, and how it all came about may now be read in the official report. The one bright spot that shines all through the Blue Book is the fact that under conditions of storm and stress the officers and men of the Royal Army Medical Corps acted up to the highest traditions of a service whose motto is self-sacrifice, and whose reward principally consists in the possession of the *mens conscia recti*.

#### Neurasthenia.

It is not often that a man assumes in public the rôle of iconoclast of the images made by his own hands. Yet this seems to be the position of Dr. Charles Dana in regard to the disease "neurasthenia," which owed its name and its recognition as a clinical entity to him in association with Dr. Beard. In a paper recently read before a New York audience (a) he declares that the word has become so misapplied that in the near future it is bound to disappear from the terminology of accurate diagnosis. At the time of its introduction the word gave greater definiteness to a group of clinical phenomena which had formerly been referred to

under the vaguest terms—"the vapours," "hypochondria," "the spleen," "liver troubles," and so on. Nowadays, however, it only serves to cloak diseases and conditions which deserve distinctive names, and it causes confusion by grouping together neuroses and psychoses. Indeed, according to Dana, the great majority of the cases passing under the name "neurasthenia" are psychoses of one sort or another, being most commonly mild forms of melancholia. For instance, the "queerness" of young persons who lose interest in their work and in the things in which their fellows are accustomed to be interested has commonly been described as "neurasthenia," whereas it is in reality a form of the insanity of adolescence. On the other hand, there are some conditions of purely physical and non-nervous origin which have been confused with neurasthenia. For instance, the "status lymphaticus" of young people gives rise to a phlegmatic condition which has often been mistaken for it, and in the old a lethargy, the result of arterio-sclerosis, has caused similar error. The word "neurasthenia," according to one of its authors, has fulfilled its function in the development of knowledge, and may be allowed to disappear.

#### Draughts in Railway Carriages.

FASHIONABLE and healthy as is the desire for fresh air, there is one form of fresh air which medical science is not required to inform people is injurious, for it is abundantly obvious to every man of common sense. We mean draughts. The chilling of one area of the body whilst the rest of the surface retains its normal heat is not only uncomfortable, but dangerous. Such chills usually affect the head and neck, because, being uncovered, they are most exposed to the influence of draughts and currents of cold air. Among minor ills thus produced, tooth-ache, neuralgia and torticollis are perhaps the commonest, but facial paralysis, which may even remain permanent, is not infrequently seen in those who have fallen asleep with cold air playing on one side of the face. Of all places the one in which it is most difficult to avoid draughts is the railway carriage, and though comfort in travelling has greatly increased during the last few years, but little has been done to make the average railway-carriage a place where pure air can be breathed without draughts being created. The northern railway companies have improved on the old hot water-tin as a carriage warmer, but the steam-heated carriage is nearly always stuffy, and the southern lines, for the most part, have taken little trouble with regard to either warming or ventilation. A correspondent of the *Times* suggests a method of keeping the rush of air created by the train from entering the carriage of such simplicity that we wonder it has not been tried long before. It consists in placing a board four inches in width to project wing-wise outside and in front of the carriage windows. The correspondent alluded to claims that by this means the carriage-windows

(a) *Medical News*, October 8th, 1904.



can be opened to any desired degree without any draught being felt by the passengers. We have not tried the experiment ourselves, but it sounds perfectly reasonable in principle, and if it is as effective in practice as it seems likely to be the railway companies should surely have no excuse for not adopting it. A long railway journey in the cold season of the year, especially to people not accustomed to travelling, is a severe menace to health, and it is little less than monstrous that this should be so at the present day.

#### Scientific Research at Khartoum.

To those who are interested in the study of tropical medicine, the report of the Wellcome Research Laboratories at Khartoum will be of particular value. It will be remembered that at the time of the establishment of the Gordon Memorial College, Mr. H. S. Wellcome, of London, fitted these laboratories and presented them to the Soudan Government. The work of carrying them on was entrusted to Dr. Balfour, as director, and the first report has recently been issued. Though Dr. Balfour has no skilled assistance provided in the laboratories, he seems to have the gift of obtaining it from his friends, and much valuable work is being done by medical and veterinary officers in the service of the Soudan Government, as well as by military medical officers stationed at Khartoum. All this work centres round the Wellcome Laboratories, and is, as it were, inspired by the director. Dr. Balfour's own work seems to be very wide, for up to the present he has rather been making acquaintance with the general facts of epidemiology in the Soudan than devoting himself to any particular line of investigation. Malaria is commoner at Khartoum than is generally supposed, and soon after Dr. Balfour's arrival an anti-malarial brigade was organised on Major Ross' lines with very gratifying results. It is noticeable that, in spite of the dry, hot climate, tuberculosis is common among the natives, but, as its incidence is greatest on women and children, it is almost certainly due to the dark, close, crowded huts they inhabit. Syphilis of very severe type is prevalent, and as among the natives it is considered rather an honour to have the disease, no steps are taken to counteract it. The Director and his friends are engaged in collecting and examining blood films from all sorts of cases of tropical disease, as well as in systematic bacterioscopic work. There is no doubt that the establishment of an institution such as that at Khartoum will lead to advances in tropical medicine which would not otherwise be made.

#### Copper as a Bactericide.

THE purification of water is admittedly one of the problems of the day, for whatever care is expended in the collection of water, the inspection of sources, and filtration, a proportion of water-borne disease persists in most large towns. Although there are more agencies than one by which typhoid may be disseminated, water is still the chief, and typhoid fever continues to occur in the

autumn with a regularity which indicates that a good deal remains to be done in the treatment of water before it reaches the consumer. What the eventual method may be, it is impossible to say, but that in the future sterilised water will be considered the only safe water for people to drink admits of but little doubt. A plan for treating water on a large scale at a nominal cost has been suggested by Dr. Moore, who has carried out experiments to attain his object, and who is convinced that he can render water free from algæ and bacteria by means of his method. This consists in adding to the water it is wished to purify, copper sulphate in the proportion of 1 to 100,000, which he claims is sufficient to kill virulent colonies of typhoid and cholera in four or five hours in water at ordinary summer temperature. We confess to feeling some surprise that so weak a solution can be efficacious, but even if it is there remains the objection that the consumers of the water would have to imbibe a certain amount of copper with the fluid. A great deal of discrepancy is still to be found among authorities as to the toxic powers of copper, but it cannot but be a big experiment to make people drink minute quantities of it in solution every day of their lives. It is claimed that less copper is contained in a gallon of water so treated than in an ordinary loaf of bread or cake of chocolate, and that therefore the amount of copper is harmless to effect any pathological changes. However this may be, purifying water by the addition of chemicals that must eventually reach the tissues of the consumers is an experiment not to be lightly tried, and it certainly is not the final solution to the problem of water sterilisation.

#### Gentleness in Manipulation.

THE importance of being extremely gentle in diagnostic manipulation was recently brought before the profession in America in a discussion (a) opened by Dr. Howard Kelly, of Baltimore, who made special reference to injuries sustained by the bowel in the course of gynecological examinations. Many other instances were enumerated, however, of the damage that may be done by the slightest roughness in performing abdominal palpation. For instance, in the experience of many of the speakers, and probably of many of our readers, such accidents have occurred as the rupture of a thin-walled cyst, or, still worse, of a localised abscess. Even the rupture of a tubal pregnancy is reported to have taken place from the energetic examination made by the relative of a patient to satisfy himself of the correctness of the diagnosis of an attending physician. The perforation of the uterus by a sound is so common an accident as to need no special mention. The accident of perforation of the rectum by the examining finger is less common, but, nevertheless, Dr. Kelly has seen it happen four times. The principal predisposing condition is a loss of muscular tone, usually occurring in elderly, flabby women. In such patients a rectal examination should be made with great

(a) *Journ. Amer. Med. Assoc.*, November 26th, 1904.

care and deliberation. The best treatment, if the accident should occur, is immediate opening of the peritoneum, preferably by the vaginal route, and suture of the rent from the peritoneal aspect.

#### Tattooing and Disease.

THE natural instinct for personal adornment, like many other primitive impulses, still survives in the present day, even among the male sex, who, if they cannot render their clothing attractive, seek to enhance their cutaneous charms by imprinting various devices and patterns upon their epidermis. As a matter of fact, it is the true skin which has the greater share in bearing the permanent decoration, for it is well known that the durability of the marks depends entirely upon the depth of the punctures. The practice of tattooing is of great antiquity, and many different substances, such as clay or pine-resin, have been introduced by native tribes beneath the skin, the use of indigo or vermilion following at a somewhat later period. The desire for early recognition and identification after death would seem to be one reason for the great popularity of tattooing among soldiers and sailors. On the other hand, many distinguished personages are thus branded with mystic emblems from wholly different motives. In the annual report of the Director-General of the Medical Department of the Navy, recently issued to the Admiralty, an interesting paper may be found by Staff-Surgeon Finch, of H.M.S. *Thetis*, which deals with the subject of the communication of disease by tattooing. In 1878, Maury and Dulles reported a series of fifteen cases in which syphilis was definitely communicated through the practice, the virus having effected an entrance into the tattooed individuals through the needles which were moistened by the lips of the operator, who was himself the subject of the disease. In these patients there had never been any pre-existing venereal affections. A further series of twelve cases was described by Surgeon F. R. Barker, in 1889, in which an outbreak of syphilis was distinctly traced to the practice. Unless the strictest aseptic precautions are observed, it is obvious that many other contagious or microbic disorders might be transmitted by any operation, however trivial, involving a puncture of the skin.

#### Steedman's Powders.

A CASE of some interest, both to medical men and chemists, was decided at the Coroner's Court, Hammersmith, last week. It appears that a child, eight weeks old, was given a Steedman's powder for the relief of pain, and twenty and a half hours later died, the symptoms being contraction of the pupils and sleep. Dr. William Robert Hall Hains, who saw the patient during life and also made the autopsy, was of opinion that death was not due to natural causes, but was accelerated by some narcotic poison. Suspicion naturally fell on the powder, and the matter was referred by the Coroner to Dr. Freyberger for report. At the adjourned inquest it was definitely stated by the proprietors

that although the composition of the powder was a trade secret, it contained neither opium nor morphine, and was free from any toxic agent. Dr. Freyberger said that he had examined not only the viscera and the contents of the stomach, but the remains of the powders, and found that they were absolutely free from any trace of opium or any narcotic substance. Dr. Wilson Hake, of the Westminster Hospital, said that he had purchased samples from various sources, and had also examined the manufacturer's stock and was unable to find narcotic acid or any opium alkaloid. Dr. Murrell stated that neither the symptoms nor the *post-mortem* appearances were indicative of opium poisoning, and that in all probability the child had died either from broncho-pneumonia or congestion of the brain. Dr. Hains, on being recalled, said that after hearing the expert evidence he was perfectly satisfied that death was due to natural causes. He asked if he had been right in refusing a death certificate. The Coroner, in reply, said that the Court was much indebted to Dr. Hains, and that he had acted very properly in the matter. A verdict in accordance with the medical evidence was returned. As the sale of these powders is said to amount to many millions in the year, this result is of some public importance, however much as a scientific profession we may and must condemn the use of nostrums under such a misleading and unscientific name.

#### The Corset Again.

THERE is no more ruthless exposé of woman's follies than the woman who has emancipated herself from their thralldom, and Miss Arabella Kenealy goes for her weaker sisters to some purpose in "The Nineteenth Century and After" this month. The bone of contention is the bone of the whale, and the way that the female of human species surrenders herself to its embrace. It hardly needs a medical expert to point out that compressing the viscera in an iron grip, so that they are distorted in shape and displaced in position, is not calculated to aid them in the performing of their physiological functions. Such a truism the silly creatures who practise the art of tight-lacing would simperingly admit themselves. What would give its quietus to the production of this artificial deformity would be the pencil of the caricaturist and the pen of the satirist, who laughed the crinoline off the stage. In the meantime, the vigorous onslaughts of Miss Kenealy are all to the good, and some of the facts certainly are not generally known. It may be news to many readers to hear that a series of experiments were made some years ago on monkeys, to study the effects of tight-lacing. The poor creatures were encased in fashionable corsets and then squeezed till their figures approximated as closely to the "wasp" type as the simian waist can approach. It is not stated under what schedule these experiments were performed, and no mention is made of anæsthetics. In spite of a natural presumption to the contrary, the ape of the woods did not show

himself possessed of the constitution of the *grande dame* of Belgravia, for some only lived a few days in their Parisian habiliments. The others lingered for months in agony, and died of disorders produced by the stays. One important—nay, vital point was overlooked by the experimenter. He was thinking so much of the duration of the monkeys' agony—which, of course, was only an incidental question—that he forget to observe if the male monkeys exhibited a more decided *penchant* for the embrace of the corseted ones than they usually do for their naked, but unashamed, colleagues. It is to be hoped that the experiments will be repeated with a view to unravelling this crucial problem.

#### Symbiosis among Bacteria.

THERE are few more enticing studies in the field of biology than that afforded by the subject of symbiosis, and few paths which lead one into more unexpected regions. Thus, for example, the classic instance of the connection between the life of certain wild bees and the presence of the domestic cat is, at first sight, quite inexplicable, yet the causal relation is simple enough. The bees are unable to cope with a large population of field mice, and the great check on the latter is the domestic cat. In the realm of bacteriology there is good reason to believe that certain instances of [symbiosis occur which are of practical importance, and the suggestions on this subject made by Dr. Klein, in his recent Dobell Lecture, open up a promising field of research. It is known, for instance, that in many cases the lesions due to a mixed infection are greater than would result from a pure infection by any one of the organisms concerned. Sometimes an infection by one organism may be causing but little damage, when the addition of another excites a startling increase of injurious processes. This occurs, for instance, when a streptococcal infection is superadded to that of the diphtheria bacillus. In such cases Dr. Klein suggests that not merely does one organism serve to prepare the ground for another, but that one in some peculiar way actually increases the virulence of the other. Similarly it is possible and probable that a tuberculous focus receives an impetus to spread from a secondary infection of different kind, and that the secondary infection directly increases the virulence of the tubercle bacillus. The difference between active and resting foci of tuberculous disease may, on this theory, be explained as due to the presence or absence of a second infection.

#### Hospital Museums.

THAT the proper study of disease is incomplete without a knowledge of the pathological changes and appearances that occur in the organs and tissues affected few will be found to deny. There are some who aver that too much time may be spent over test-tubes and microscopes, and, to some extent, there is a danger lest the office of the bacteriologist or the chemical physiologist be un-

duly magnified. It is in the dead-house, however, that the closest acquaintance is made with actual disease-processes, and the practitioner who is most familiar with morbid pathology is in a far better position to tackle a difficult case than the casual visitor to the *post-mortem* room. What medical man has not experienced the peculiar thrill, akin to awe and reverence, excited by a typical specimen of some strangely altered organ seen or handled for the first time? It is the contemplation of such a departure from the normal which fills the studious onlooker with a deeper desire to find out the reason why such things befall the human body. His enthusiasm is stirred, and if he possess any fraction of the spirit of scientific research he will not rest until he has thoroughly grasped the nature of the disease in question. It is the most natural thing in the world, therefore, that the clinical museum should be not the least important part of the modern hospital equipment, more especially if there be a medical school or post-graduate college attached to the institution. Professor Thomas McCrae, of New York, is impressed by the fact that, taken all round, the hospital museums in this country are accessible to students and are really utilised as places of study. This is certainly the case as far as the great centres of medical education are concerned, but we fear that even now in some of the smaller hospitals the museum is conspicuous by its absence, or is relegated by the governing body to the worst and most badly-lighted quarters of the building. It sometimes happens that good specimens are lost or thrown away by practitioners simply because the nearest hospital to them has no museum. There is certainly room for more enterprise on the part of hospital authorities in this direction.

#### PERSONAL.

HIS MAJESTY THE KING has graciously been pleased to grant the title "Royal" to the Victoria Hospital for Consumption, Edinburgh.

A DINNER, given on December 11th, to Professor Koch to celebrate the sixtieth anniversary of his birthday was attended by a great many of his former assistants, including Professor Brieger, Professor Löffler, Professor Gärtner, and others. All the members of the Institution for Infectious Diseases were present.

LORD STRATHCONA and MOUNT ROYAL will preside at a festival dinner to be held at the Whitehall Rooms, Hotel Metropole, London, S.W., in aid of the National Hospital for the Paralysed and Epileptic on April 12th next.

THE foundation stone of the Llanybytheris Sanatorium for consumptives for the counties of Cardigan, Carmarthen, and Pembroke, is to be laid on April 26th, 1905, by Princess Christian.

DR. E. S. STOKES has been appointed medical officer and bacteriologist to the Metropolitan Board of Water-supply and Sewage, Sydney.

MR. EDWARD TURNER BORN, M.B. Dunelm, J.P., has been promoted from Assistant Colonial Surgeon, Fox Bay, West Falklands, to the Hon. the Colonial

Surgeon, Stanley, East Falklands, President Board of Health, and Member Executive and Legislative Councils

MR. T. CRISP ENGLISH, B.S. Lond., F.R.C.S. Eng., has been appointed Assistant Surgeon to St. George's Hospital and Lecturer on Operative Surgery, St. George's Hospital Medical School.

DR. A. P. LUFF has been appointed Physician to the In-patients at St. Mary's Hospital.

ON the 15th instant, Miss Amy Sawyer, third daughter of Sir James and Lady Sawyer, of Birmingham, was married to Mr. H. H. French, of Guy's Hospital.

DR. WALTER SMITH, King's Professor of Materia Medica and Pharmacy in School of Physic, Trinity College, Dublin, has been appointed to examine at Examinations of Army Medical Service.

DR. J. MAGEE FINNY, ex-president R.C.P.I., has been appointed Honorary Consulting Physician to the Royal Hospital for Incurables, Donnybrook, Dublin, in place of the late Dr. John J. Cranny.

COLONEL (temporary Surgeon-General) W. F. Stevenson, M.B., C.B., Royal Army Medical Corps, Professor of Clinical and Military Surgery, Royal Army Medical College, has been appointed an Honorary Surgeon to the King, *vice* Surgeon-General J. Jameson, M.D., C.B., deceased.

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, *vice* Professor Bertram C. A. Windle, M.D., F.R.S., resigned upon appointment as President of Queen's College, Cork.

### Obituary.

ARTHUR QUARRY SILCOCK, M.D. LOND., B.Sc., F.R.C.S.

WE regret to announce the death of Mr. Arthur Quarry Silcock, the eminent surgeon and ophthalmologist, which occurred on the 19th instant, after a short illness, at his residence, 52, Harley Street, at the premature age of 49. Born at Chippenham, Wiltshire in 1855, he was educated privately at University College, London, taking the B.Sc. degree at London University in 1878, and being admitted the same year as a member of the Royal College of Surgeons, England. In 1880 he proceeded to the M.D. degree, and in 1882 was elected a Fellow of the Royal College of Surgeons. Dr. Silcock, in the course of a successful professional career, filled many important positions. He held the post of senior demonstrator of anatomy and demonstrator of practical surgery at University College Hospital, where he was also surgical registrar, house physician, and house surgeon. He was pathologist and lecturer on practical and operative surgery and pathology at St. Mary's Hospital, and had also been president of the University College Medical Society. At the time of his death he held the offices of surgeon and joint lecturer on surgery at St. Mary's Hospital, surgeon to the Royal London Ophthalmic Hospital, consulting surgeon to the Bromley Cottage Hospital, and examiner in surgery for the Royal College of Surgeons. Dr. Silcock was a Fellow of the Royal Medical and Chirurgical Society, and a member of the Ophthalmic, Clinical, Pathological, and Harveian Societies. He was the author of "Injuries of the Eye" in "Druitt's Surgeon's Vade-Mecum" and had contributed a large number of papers to the transactions of the Pathological, Clinical, and Ophthalmic Societies, as well as many articles to the professional journals.

GEORGE ANDREW CAMPBELL, M.D. Ed., R.N. DEPUTY Inspector-General of Hospitals and Fleets

George Andrew Campbell, M.D., R.N. (retired), of 2, St. Leonard's Road, Ealing, whose death on the 19th instant, at the age of 68, is announced, was educated at Harvard, U.S.A., and at Kingston, Canada, where he took his M.D. degree in 1859. Entering the Navy in 1860, he became a staff-surgeon in 1872, and in that rank served in the *Hecle* at the bombardment of Alexandria, on July 11th, 1882, during the Egyptian campaign which followed, and throughout the naval and military operations near Suakin, in the Eastern Soudan, in 1884. For his war services he received the Egyptian Medal, with the Alexandria and Suakin clasps, and the Khedive's bronze star. He was promoted to the rank of fleet-surgeon in 1883, and retired in 1891 as a deputy-inspector-general.

CHARLES FREDERICK LAING, M.D.

THE death took place at sea, near Gibraltar, on Tuesday week, of Dr. Charles F. Laing, medical superintendent of Somerset and Bath County Asylum. A few days ago Dr. Laing started on a voyage for his health, and he was on his way to Egypt when the sad occurrence took place. Dr. Laing, who was only in his 36th year, was born at Paisley. He was a son of the late Mr. Charles W. Laing, governor of the Town's Hospital, Glasgow, and was educated at the High School and Allan Glen's School, and afterwards at Glasgow University, where he graduated M.B., C.M. in 1890. A year later he received an appointment at Smithston Asylum, Greenock, and from there went to Cheshire County Asylum at Macclesfield as assistant. Three years ago he was selected from a large number of applicants as superintendent of the important county asylum at Wells. Dr. Laing was well known in Glasgow. By his death a career full of promise has been prematurely closed.

### Correspondence.

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

HOSPITAL FUNDS AND SMALL HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Hospitals exist primarily for the relief of the suffering poor; they are further needed to provide clinical material for the education of students of medicine, and they furnish a field for the scientific observation and study of disease and pathological phenomena. Hospitals do not, or at least should not, exist for the purpose of enabling a few practitioners to get on in the world; but this seems to be the idea of some correspondents who so far have taken notice of my letters. This latter is, in fact, the purpose for which most existing special hospitals were founded, and for which some of them are being still employed. This no doubt suits some individuals; but it is very bad for the bulk of the profession. The whole special hospital system is associated with other evils, some of which I have previously referred to, and it is the cause of waste of public funds which, if applied to legitimate ends, would serve almost alone to satisfy the needs of great institutions which in every essential respect are beyond criticism.

I am, Sir, yours truly,

December 21st, 1904.

HENRY SEWELL.

THE LONDON HOSPITAL FUNDS, THE LONDON HOSPITAL AND Mr. STEPHEN COLERIDGE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Stephen Coleridge has forwarded to me, with his compliments a copy of your issue of December 21st. I am very grateful to him, and I congratulate you on having obtained so active and zealous a propagandist of your views.

I do not expect from you any too charitable a view of my conduct or motives. I have never received anything but hostile criticism from you ever since I have worked for hospitals. I may be wrong, and you

always right—quite likely. But you will allow me, I am sure, to reply to your criticisms in your leading article in that number.

In the first place you criticise me for taking upon myself the defence of a grant from a hospital "to its college"—that is a better way of describing this than "to its school," because the grant is not made towards the education of students, but in return for very valuable services rendered by the Professors of the college, and by the students, to the hospital. But let this pass. You criticise me for replying because I am "a subscriber to, and not an official of, the Sunday Fund." This is a little unfortunate, for I have been a member of the Council for many years.

I might not, however, have spoken at all, had not the Rev. Lionel Lewis made a very violent attack on the London Hospital because we, as he puts it, spent £7,000 on a cricket ground, while his poor people were dying for want of hospital accommodation (his parish is in Hoxton not Whitechapel). He held me up to scorn as cruel, extravagant and unmindful of the crying needs of the sick poor.

Surely this is a little rough on a man, who, however wrong according to you in all his ways, at any rate may be supposed to care something for the sick poor; or else to be an idiot for devoting the best part of his leisure to hospital work. You have never suggested that I am quite an idiot, so I take it you will not go so far as to agree with this minister of the Gospel of Peace and Goodwill.

What are the facts—facts which I was driven by the above sneer to give, and facts which, when known to the rev. gentleman brought no apology from him. We bought, and spent on a cricket ground—£6,000, not £7,000. But before doing so we had made an agreement to let it on lease at 4 per cent. on our expenditure to a very prosperous Club, composed of all our students (£2 2s. a year subscription). They asked us to lend them the money at this rate on the security of the ground. But we were very strongly advised by experts to purchase the freehold ourselves. And their advice has been right. To-day we could sell the ground for far more than the £6,000.

You write "the point was whether the hospital had any right to invest charitable funds in the purchase of a cricket ground." Why not? if it pays as much as in a ground lease or leases, or land round the hospital, or in Consols—an investment, by the bye, in which a hospital can lose a good deal, as I know to my cost.

How very unfair also is your remark that "Mr. Holland was silent when asked if the accounts of the school were sent to every subscriber." It is difficult to believe that your reporter did not hear my reply. I was challenged on the point, and gave a direct answer, not in the middle of my speech, but a direct answer to the Lord Mayor, that every subscriber to the hospital could have a copy of the College accounts which are printed, and audited by a chartered accountant.

Attack me as much as seemeth good unto your circulation. But play fair, and do not show any personal animosity in controversial criticism.

I am, Sir, yours truly.

SYDNEY HOLLAND.

December 24th, 1904.

[Our personal respect for Mr. Holland's good faith and honourable intention has often been warmly expressed. At the same time, we have been obliged to differ from him at times. In the present instance, a point of vital importance is involved, namely, the diversion of funds subscribed for purely hospital purposes. The £6,000 was devoted to the purchase of a "sports" ground, not as a hospital endowment investment. Mr. Holland must give us the same credit for fairness of purpose that he claims for himself. We shall afford him every opportunity of a full statement and discussion in these columns. Mr. Coleridge is also entitled to full expression, however unhesitatingly we may condemn his anti-vivisection tactics.—ED. M.P. & C.]

## Medical News.

### Poisoned by Gelsemium.

At the assizes at Leeds on December 10th, a grocer was charged with the manslaughter of a girl. The story as it stands seems highly improbable, for it runs that the girl went to the shop to purchase fuller's earth. The grocer said he did not keep it but advised her to try witch-hazel. In mistake he sold her gelsemium and the girl died shortly after taking it. Mr. Justice Darling said there was no evidence of criminal negligence and the jury by his advice, returned a verdict of not guilty.

### Prosecution of an Unregistered Dentist.

At the Cardigan police court on December 12th, a man was fined 20s. and costs for falsely taking and using the name of a dentist without being registered in accordance with the provisions of the Dentists Act, 1878. He stated, in defence that he had a certificate of proficiency from an American college.

### New Regulations of the Royal University of Ireland.

THE Royal University of Ireland has issued the following new regulations in reference to the final M.B. examinations:—(1) In the spring and again in the autumn of each year two separate examinations will be held simultaneously, one for pass candidates only, the other for honour candidates only. When entering each candidate must state at which of these examinations he elects to be examined. A candidate who has entered for the honour examination may be allowed to change to the pass examination on giving to the secretaries a satisfactory reason for doing so at least one week before the commencement of the examination; but under no circumstances will a candidate who has entered for the pass examination be allowed to change to the honour examination. (2) Honour exhibitions will be awarded on the results of the honour examination only. (3) Candidates at the honour examination whose answering may not be such as to qualify them for honours may nevertheless be adjusted to have passed the examination provided they exhibit in their answers knowledge equivalent to what is required from candidates who satisfy the examiners at the pass examination.

### University of Oxford.

IN a congregation held on December 17th, the last day of Michaelmas term, presided over by the Vice-Chancellor (Dr. Merry, Rector of Lincoln College), the following degrees were conferred:—

M.D.—H. P. Cholmeley and E. Mallam, Magdalen.

M.B. and B.Ch.: E. Burstal, Trinity; R. A. Chisolm, Wadham; and H. R. Dean, Magdalen.

D.Sc.: T. C. Porter, Exeter; and H. B. Baker, Christ Church.

*Final Examination.*—Medicine, Surgery, and Midwifery: A. W. Brodribb, University College; E. Burstal, Trinity; R. A. Chisolm, Wadham; H. R. Dean, Magdalen; H. Frankish, Worcester; J. Freeman, University College; A. H. Hogarth, and R. H. Sankey, Christ Church; C. J. Singer, Magdalen; E. Mc.L. Smith, Queen's; P. F. Tinné, Magdalen; and J. A. Vlasto, New.

### Royal College of Physicians of Edinburgh.

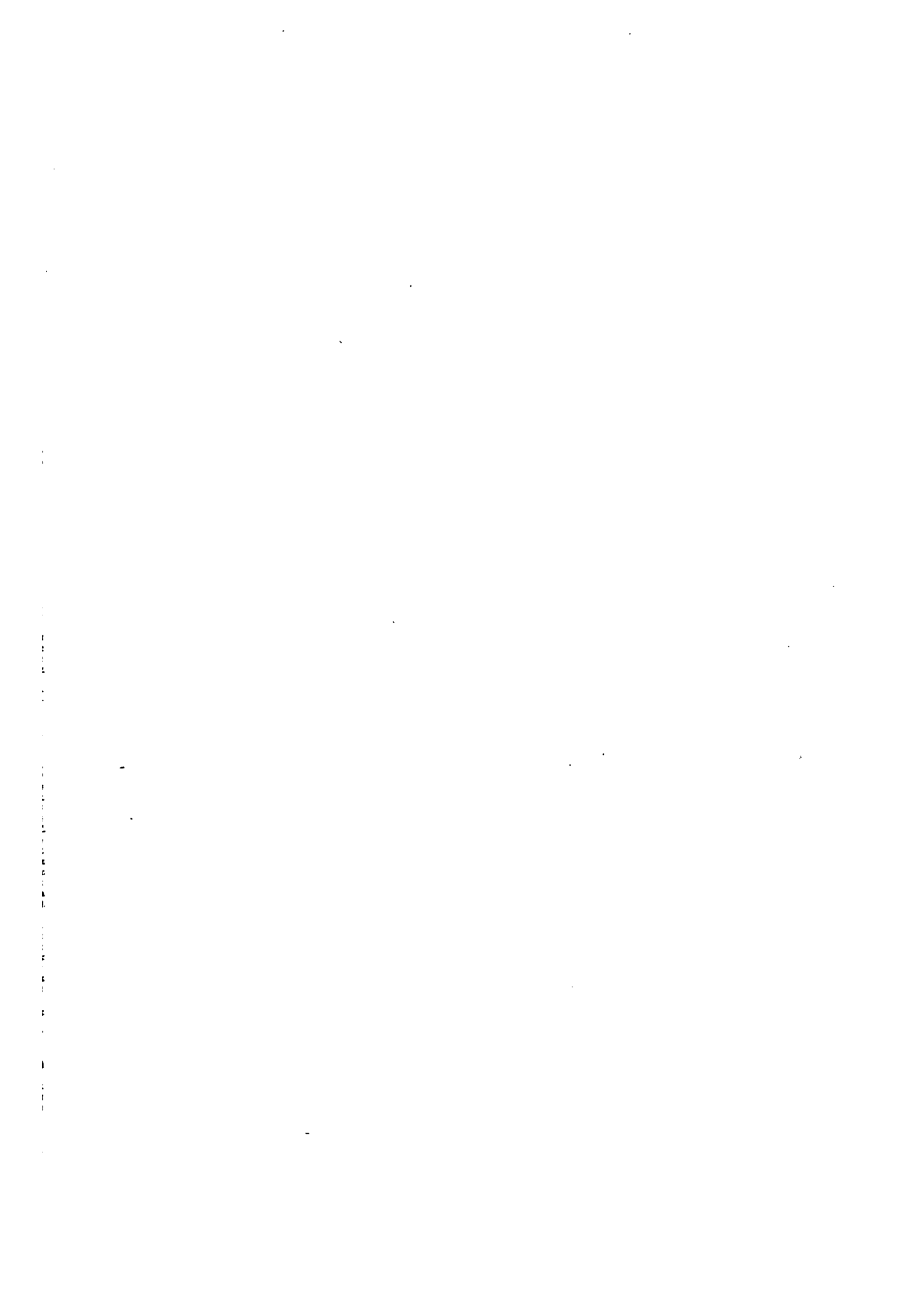
At a recent meeting of the Royal College of Physicians of Edinburgh, Dr. John Playfair was elected President of the College; Dr. Thomas S. Coulston, Vice-President; and Sir Thomas R. Fraser, Sir John Batty Tuke, Dr. Charles E. Underhill, Dr. James Ritchie, and Dr. R. W. Philip were elected to the Council with the President and Vice-President.

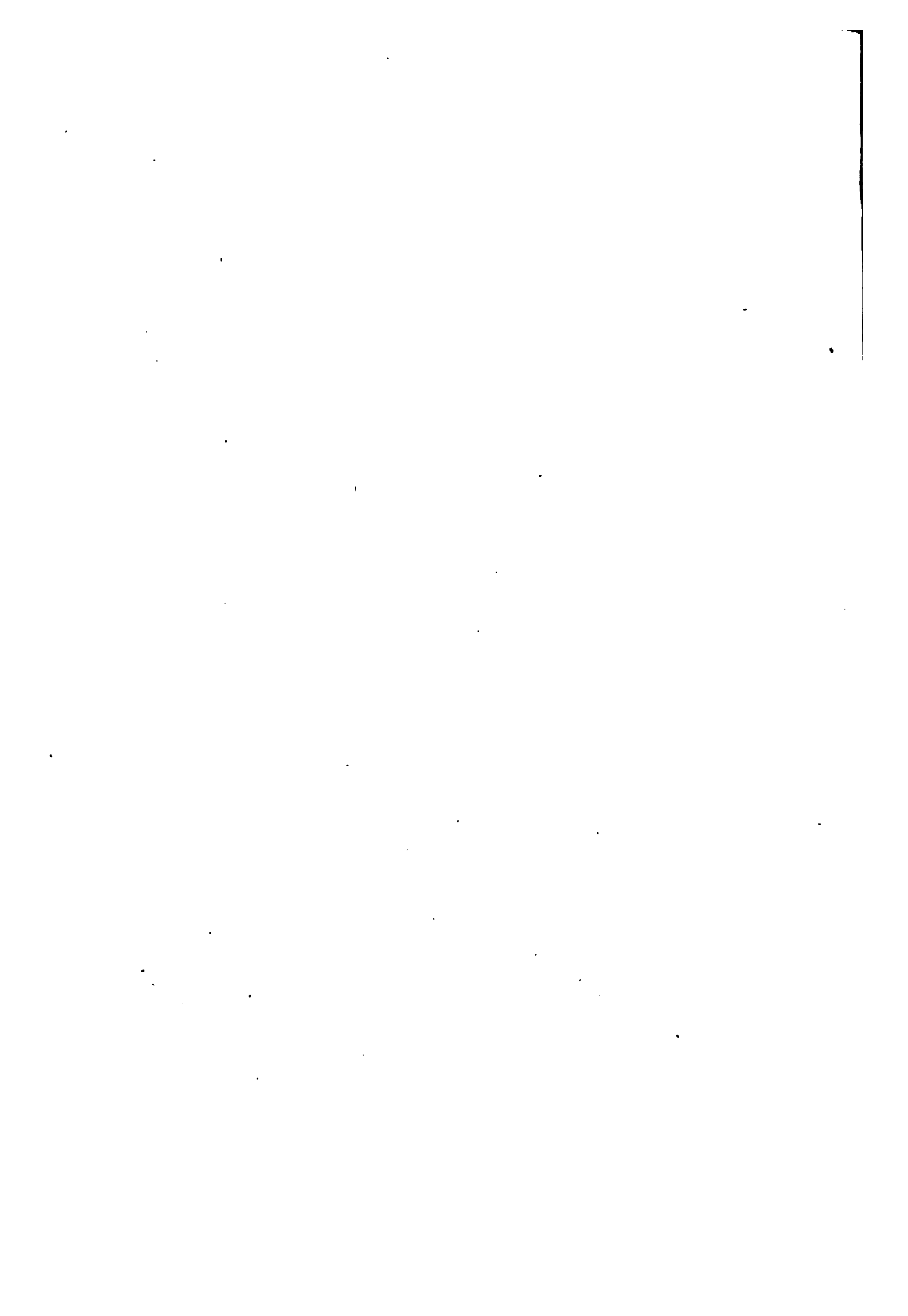
### Trinity College, Dublin.

*Michaelmas Term, 1904:*—The following candidates passed the Final Examination in Surgery: Eva J. Jellett, Hugh Stewart, William Hassard, Thomas Creaser, Robertson S. Smyth, John Cunningham, Richard Kelly and Arthur A. M'Neight (equal), Charles E. Fawcett, Thomas J. T. Wilmot, Thomas Wilson, Gerrard A. Crowley, Keith R. C. Hallows, William J. M'IVOR.

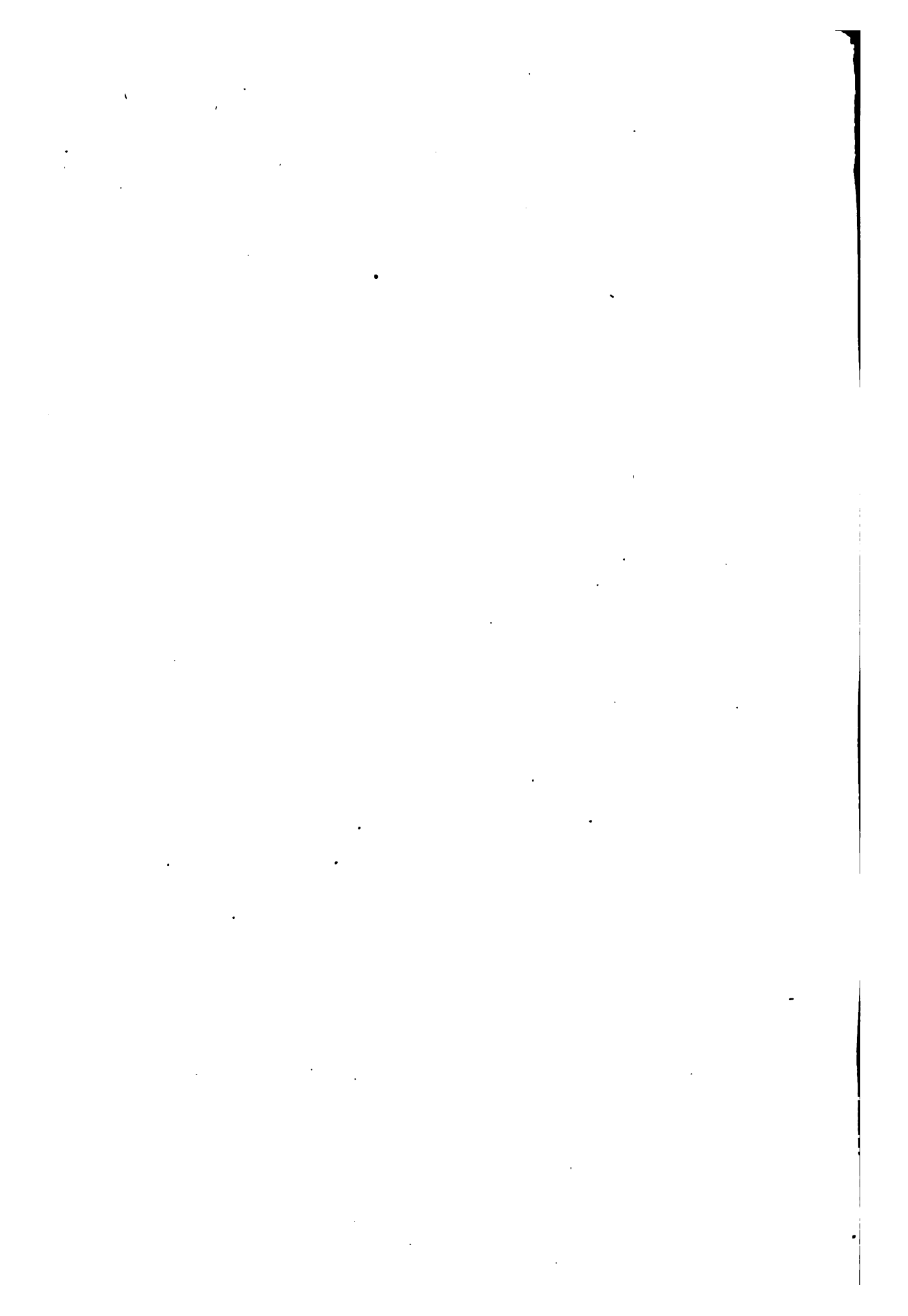












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